Associated Neurological Specialties and Sleep Disorder Center

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DATE: _____ PATIENT NAME: _____ DOB: _____

CONCUSSION QUESTIONNAIRE

1. Date of Concussion _____
2. Did patient lose consciousness? _____

   If so, for how long? _____
3. What was the patient's last memory or last recall before the injury?

   What was the patient's first memory or recall after the injury?
4. Was there associated nausea? _____ Or nausea and vomiting? _____
5. Was there associated memory disturbance? _____
6. Was there any associated dizziness? _____ If so, describe the dizziness:
7. Was there any associated headache? _____ If so, describe the headache:
8. Was there any associated balance disturbance? _____ If so, please describe:

9. Was there any associated sleep disturbance? _____ If so, please describe:

   Was there any disturbance of dreams? _____ If so, please describe:

10. Was there any change in work performance or school performance? _____
    If so, please describe:

11. Is there a history of previous concussions with or without loss of consciousness? _____
    If so, please describe:

12. Was there any hearing loss or ringing in the ears? _____ If so, please describe:

13. Was there any associated depression or anxiety related to the injury? _____
    If so, please describe:

14. Was there any change in mood or increased irritability? _____ If so, please describe:

15. Are you gradually getting better, the same, or worse? _____ Please describe: