



ImPACT™

Office use only:

Date: \_\_\_\_\_

Exam

Room: \_\_\_\_\_

# Baseline Worksheet

## I. Demographic and Background Information

General

Name \_\_\_\_\_ DOB \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

School/ Organization \_\_\_\_\_

Handedness: R or L or Both      Gender: Male or Female

Language

Native Language \_\_\_\_\_

Education

Years of Education Completed (e.g., high school senior is 11 years) \_\_\_\_\_ years

### Check any of the following that apply:

- Received speech therapy
- Attended special education classes
- Repeated one or more years of school
- Diagnosed attention deficit disorder or hyperactivity
- Diagnosed learning disability

Sports

Current Sport: \_\_\_\_\_

position/ event/ class \_\_\_\_\_

level of participation \_\_\_\_\_  
(e.g.: high school, semi-professional, collegiate etc)

years of experience at this level: \_\_\_\_\_  
(approximate if needed; e.g., high school senior is 3 years)

Concussion

Number of times diagnosed with a concussion: \_\_\_\_\_

Total number of concussions that have resulted in loss of consciousness

- Total number of concussions that resulted in confusion.
- Total number of concussions that resulted in difficulty with memory of events occurring immediately after injury.
- Total number of concussions that resulted in difficulty with memory of events occurring immediately before injury.
- Total number of games that were missed as a result of concussions

**Please List your five most recent concussions:** \_\_\_\_\_  
**(use approximate dates if needed)** \_\_\_\_\_

**Indicate whether you have experienced the following:**

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treatment for headaches by physician                           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treatment for migraine headaches by physician                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treatment for epilepsy/ seizures                               |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | History of brain surgery                                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | History of meningitis  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treatment for substance/ alcohol abuse                         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treatment for psychiatric condition (depression, anxiety etc.) |

## **II. Current symptoms and conditions**

**Date of last concussion:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **(month- day- year)**

**Total hours of sleep last night:** \_\_\_\_\_ hours

**Current medications:** \_\_\_\_\_