ADVANCE CONCUSSION CLINIC Play Hard. Play Safe.™

Affix Patient Label Here

Injury History **Date of Injury:** _____

1. **Injury Description** _____

_____

2. Was there evidence of injury? ☐Yes ☐No ☐ Unknown
3. Was there imaging (i.e. CT, MRI) done? If yes, please attach reports/imaging. ☐Yes ☐No
   Type_____
4. **Cause:** ☐ MVA ☐ MVA v. Pedestrian ☐Fall ☐Assault ☐Sports or Other (*specify)*_____

Loss of Consciousness: ☐Yes If yes, duration _____ ☐No ☐Unknown

Seizures: Were seizures observed?☐Yes If yes, details _____ ☐No ☐Unknown

Patient's Primary Complaint: _____

Risk Factors:

Concussion History? *(circle one)* **Y** **N**	**Developmental History**
If yes, specify #: _____	Learning disabilities
Headache History? *(circle one)* **Y** **N**	ADHD
History of migraine headache Patient_____Family History_____	Other developmental disorder
Psychiatric History *(circle one)* **Y** **N**	**Sleep Disorder?** *(circle one)* **Y** **N**
Anxiety	Please specify
Depression	If yes, what treatment if any
Other _____	

List other medical conditions and all current medications (e.g., hypothyroid, diabetes) _____

Physician Comments/Referral Specific Questions:

Diagnosis: Concussion ☐ Yes ☐ No ☐ Other _____

Upcoming Medical Investigations/Tests: _____

Best practice is interdisciplinary treatment for concussion.

Opt out of: ☐ OT ☐ PT ☐ AT ☐ CC Reasons _____

Physician Signature: _____

Suite 110 – 1367 West Broadway Vancouver, BC V6H 4A7 * Phone: 604.428.8778 * Fax: 604.998.2257