St.Charles Orthopedics
unparalleled skill | compassionate care

ThinkSMART!
Concussion Management Program

Danielle DeGiorgio, DO

Confidential Medical History
Concussion: Initial Intake Form

Patient Name: _____ Date of Birth: _____ Date of Injury: _____

Age:_____ Height: _____ Weight:_____ Current Sport:_____

Occupation/School:_____ Who referred you?_____

How did the injury occur?_____

Did you lose consciousness? Yes No

Do you remember everything before the injury? Yes No After the injury? Yes No

Were you seen at the ER? Yes No If Yes, any imaging done? MRI CT Scan Xray None

Have you ever had a prior concussion? Yes No If Yes, how many?_____Date of most recent:_____

Do you have ADD/ADHD or other learning disability? Yes No _____

Personal or family history of anxiety/depression or other psychiatric disorder? Yes No _____

Personal or family history of migraines or chronic headaches? Yes No _____

Do you have any other medical conditions? _____

Underline your initial symptoms. ***Circle*** your current symptoms: NONE

Headaches	Sensitivity to noise	Problems remembering	Drowsiness
Nausea	Numbness/tingling	Feeling slowed down	Sleeping more
Fatigue	Vomiting	Irritability	Sleeping less
Visual Problems	Dizziness	Sadness	Trouble falling asleep
Balance Problems	Feeling mentally foggy	Feeling more emotional	
Sensitivity to light	Problems concentrating	Nervousness	

Do any of the above symptoms worsen with physical or mental exertion? Yes No

Are you currently taking any medications for the above symptoms? (If yes, please list)_____

Patient Name: _____ Date of Birth: _____

Medical History

Please list your medical problems, e.g., high blood pressure, diabetes, high cholesterol, depression, and any condition for which you are prescribed a medication, etc.: _____

_____

_____

Females only – Do you think you might be pregnant at this time? □ Yes □ No

Surgical History

Have you ever had surgery? □ Yes □ No

If yes, please describe: _____

Family History

Please list the medical problems of your immediate family, e.g., arthritis, bleeding problems, cancer, diabetes, heart disease, high blood pressure, neurologic problem, osteoporosis, etc.:

Mother: _____

Father: _____

Sibling(s): _____ □ Not applicable

Social History

Marital status: □ Single □ Married □ Partner □ Divorced □ Widowed

Do you have children? □ Yes □ No If yes, how many? _____

Are you currently employed? □ Yes □ No □ Retired

If yes, please list your employer and occupation: _____

Do you use tobacco? □ Yes □ No If yes, how much and how often? _____

Do you use alcohol? □ Yes □ No If yes, how much and how often? _____

Before your current injury/symptoms, please describe your typical physical activity: _____

_____

Are there any upcoming events that may affect your treatment plan, e.g., race, competition, travel? _____

_____

Medications

Please list your current medications, both prescription and over-the-counter: _____

_____

Please list any supplements that you take regularly: _____

Allergies

What medications are you allergic to? _____

Are you allergic to contrast dyes? □ Yes □ No Are you allergic or sensitive to latex? □ Yes □ No

Patient Name: _____ Date of Birth: _____

Review of Systems

Please check any symptom below that you are currently experiencing or have experienced in the past few weeks:

Abdominal pain	□ Yes	□ No	Glasses	□ Yes	□ No
Anxiety	□ Yes	□ No	Headache	□ Yes	□ No
Balance problem	□ Yes	□ No	Hearing loss	□ Yes	□ No
Blood in urine	□ Yes	□ No	Hot flashes	□ Yes	□ No
Blurry vision	□ Yes	□ No	Immune system issue	□ Yes	□ No
Bowel incontinence	□ Yes	□ No	Insomnia	□ Yes	□ No
Cellulitis (infection)	□ Yes	□ No	Irregular heartbeat	□ Yes	□ No
Chest pain	□ Yes	□ No	Joint pain	□ Yes	□ No
Cold intolerance	□ Yes	□ No	Joint stiffness	□ Yes	□ No
Constipation	□ Yes	□ No	Muscle aches	□ Yes	□ No
Contacts	□ Yes	□ No	Nose bleeds	□ Yes	□ No
Coordination problem	□ Yes	□ No	Pain with urination	□ Yes	□ No
Cough	□ Yes	□ No	Rash	□ Yes	□ No
Depression	□ Yes	□ No	Ringing in ears	□ Yes	□ No
Diarrhea	□ Yes	□ No	Seasonal allergies	□ Yes	□ No
Double vision	□ Yes	□ No	Seizure	□ Yes	□ No
Easy bleeding	□ Yes	□ No	Shortness of breath	□ Yes	□ No
Easy bruising	□ Yes	□ No	Sore throat	□ Yes	□ No
Eating disorder	□ Yes	□ No	Urinary incontinence	□ Yes	□ No
Excessive thirst	□ Yes	□ No	Weight gain	□ Yes	□ No
Fatigue	□ Yes	□ No	Weight loss	□ Yes	□ No
Fever/chills	□ Yes	□ No	Wheezing	□ Yes	□ No

What goals do you have for today's visit? _____

_____

Is there anything else that you would like your care team to know about you? _____

_____

Would you like today's note to be sent to another physician? □ Yes □ No

If yes, please complete a Release of Information form and provide your doctor's information.
Release of Information form can be found at the front desk

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____