



## **Baseline Concussion Test**

### **Client Information Sheet**

#### **General**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Gender: **M / F**

Age: \_\_\_\_

Handedness: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Birthplace: \_\_\_\_\_

First Language: \_\_\_\_\_

Second Language: \_\_\_\_\_

Years Speaking 2<sup>nd</sup> Language: \_\_\_\_\_

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#### **Education**

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

Current Level of Education: \_\_\_\_\_

Have you repeated any grades? **YES / NO**

Have you had any speech therapy? **YES / NO**



# PEAK CENTRE FOR HUMAN PERFORMANCE

Have you attended any special education classes? **YES / NO**

Do you have a documented learning disability? **YES / NO**

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## Sport

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

Level of Play: \_\_\_\_\_

Years played at this level: \_\_\_\_\_

Position: \_\_\_\_\_

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## Medical

Have you received treatment for the following:

Migraines: **YES / NO**

Epilepsy/Seizures: **YES / NO**

Brain surgery: **YES / NO**

Meningitis: **YES / NO**

Substance/Alcohol Abuse: **YES / NO**

Psychiatric Condition (depression, anxiety): **YES / NO**

Have you ever been diagnosed with:

ADD/ADHD: **YES / NO**

Dyslexia: **YES / NO**

Autism: **YES / NO**



# PEAK CENTRE FOR HUMAN PERFORMANCE

Have you performed any strenuous activity in the last 3 hours? **YES / NO**

If yes, please explain: \_\_\_\_\_

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## Concussion History

Number of Diagnosed Concussions (excluding current): \_\_\_\_\_

Number of concussions resulting in a loss of consciousness: \_\_\_\_\_

Number of concussions resulting in confusion: \_\_\_\_\_

Number of concussions resulting in trouble remembering events that occurred immediately after the injury: \_\_\_\_\_

Number of concussions resulting in difficulty remembering the event/game: \_\_\_\_\_

Total games missed as a result of all concussions combined: \_\_\_\_\_

Please list, to the best of your memory, when all of your concussions occurred:

#1: \_\_\_\_\_

#2: \_\_\_\_\_

#3: \_\_\_\_\_

#4: \_\_\_\_\_

#5: \_\_\_\_\_