Appendix 2 Pre Impact Worksheet

Date of birth _____/_____/_____
Month Day Year

First Name:_____

Last Name:_____ (no hyphens)

Height ____'____" Weight _____lbs Gender Male Female

Handedness Right Left Place of Birth _____

1st Language: _____
2nd Language: _____(only if you are Fluent in 2nd language)

Ethnicity_____

Year of education completed, excluding Kindergarden
Freshman=8 Sophomore=9 Junior=10 Senior=11

Circle any of the following that apply to you

Yes	No	Receive speech therapy
Yes	No	Attended special education classes
Yes	No	Repeated one or more years of school
Yes	No	Diagnosed with a learning disability
Yes	No	Diagnosed with attentiondeficit disorder (ADD) or hyperactivity (ADHD)

In school What type of student are you?
Below Average (C – D) Average (B – C) Above Average (A – B)

Current Sport: _____ Junior Varsity Varsity
(JUDO = Martial Arts, Paddling = Boating)
Current Position or weight class_____
Years of **HIGH SCHOOL** experience in this sport (not counting this season) _____

Number of times Diagnosed with a concussion (excluding current injury) _____

Total number of concussions that resulted in:

_____ Loss of consciousness
_____ Confusion
_____ Difficulty with memory for events occurring immediately **after** injury
_____ Difficulty with memory for events occurring immediately **before** injury
_____ Total games that were missed as a direct result of all concussions combined

List your 5 most recent concussions: (month/year) ____ ____ ____ ____ ____

Indicate whether you have experienced **TREATMENT** for:

Yes	No	Headaches by physician
Yes	No	Migraine headaches by Physician
Yes	No	Epilepsy/seizures
Yes	No	Brain Surgery
Yes	No	Meningitis
Yes	No	Substance/Alcohol abuse
Yes	No	Psychiatric Condition (depression/anxiety)

Have you ever been diagnosed with any of the following conditions?

Yes	No	ADD/ADHD
Yes	No	Dyslexia
Yes	No	Autism

Have you participated in any strenuous exercise (or Practice) in the last 3 hours?
Yes No

Date of Last Concussion (current one) ____/____/____

Hours of sleep last night _____

Are you currently on medications? Yes No
If yes, Please list:_____