

Midland Christian School
Pre-Season Concussion–Assessment Baseline Test

Athlete: _____

Sport: _____

Date of Baseline Test: _____

Grade: _____

RISK FACTORS:

Concussion History

Previous concussion? **Y** **N**

 If yes, number of previous concussions **0** **1** **2** **3+**

Have you ever been hospitalized for a head injury? **Y** **N** Date of most recent concussion? _____

Additional Risk Factors: Personal History

Have you ever been diagnosed with:

- _____ Headache or migraines
- _____ Learning disability / dyslexia
- _____ ADD / ADHD
- _____ Psychological disorder
- _____ Seizure disorder

Family History

Has anyone in your family been diagnosed with:

- _____ Headache or migraines
- _____ Learning disability / dyslexia
- _____ ADD / ADHD
- _____ Psychological disorder
- _____ Seizure disorder

Are you on any medications? If yes, please list _____

How do you feel at this time? (Check only the symptoms you feel at this time)

- | | |
|--------------------------------|------------------------------|
| _____ Headache | _____ Blurred vision |
| _____ Unsteady | _____ Change in Vision |
| _____ Dizzy | _____ Ringing in the ears |
| _____ Foggy | _____ Balance problems |
| _____ Confused | _____ Slowed down |
| _____ Difficulty concentrating | _____ Irritable |
| _____ Light-headed | _____ Feeling more emotional |
| _____ Sensitive to noise | _____ Difficulty sleeping |
| _____ Sensitivity to light | _____ Numbness or tingling |
| _____ Don't feel right | _____ Neck pain |
| _____ Low energy | |

Total # Symptoms: of 21 = _____

This guide is not intended to be a substitute for clinical judgment and does not constitute a standard of medical care.

The information on the evaluation was obtained from Indiana Sports Concussion Network.

The Midland Christian School Athletic Trainer will use this base line, evaluation of the cranial nerves, a concussion symptom checklist, and a Standardized Assessment of Concussion (SAC) form to assess the Athlete for a concussion.