Texas Health Sports Concussion Center - Plano
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Sport ImPACT Baseline Testing Worksheet

REQUIRED

First Name: _____ **Last Name:**_____

Date of Birth: _____

Gender: **Female** **Male**

Have you ever been diagnosed with attention deficit disorder or hyperactivity? **YES** **NO**

Have you ever been diagnosed with a learning disability? **YES** **NO**

Have you had a concussion in the last six months? **YES** **NO**

OPTIONAL

Native country: _____

Native language: _____

Years of education completed, excluding kindergarten (example: high school senior = 11): _____

(Circle any of the following that apply)

Received speech therapy YES NO

Attended special education classes YES NO

Repeated one or more years of school YES NO

While in school, what kind of student were/are you? *(circle one)*

Below Average Average Above Average

Current sport: _____

Current position/event/class: _____

Current level of participation *(circle one):* High school Junior high

Approximate years of experience at this level: _____

___ Number of times diagnosed with a concussion

___ Number of concussions that resulted in loss of consciousness

___ Number of concussions that resulted in confusion

___ Number of concussions that resulted in difficulty remembering events occurring immediately after injury

___ Number of concussions that resulted in difficulty remembering events occurring immediately before injury

___ Combined number of games missed as a direct result of all concussions

Indicate whether you have been treated for the following :

Headaches by physician Yes No

Migraines by physician Yes No

Epilepsy/ seizures Yes No

Brain surgery Yes No

Meningitis Yes No

Substance/ Alcohol Yes No

Psychiatric condition (depression, anxiety) Yes No

Have you ever been diagnosed with any of the following?

Dyslexia Yes No

Autism Yes No

Have you participated in any strenuous exercise in the last three hours? Yes No

Hours of sleep last night (approximate if uncertain): _____

Current medications: _____