

Medical Associates, Inc.

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OFFICE OR OFF-FIELD ASSESSMENT

Please note that the neurocognitive assessment should be done in a distraction-free environment with the athlete in a resting state.

STEP 1: ATHLETE BACKGROUND

Sport / team / school:						
Date / time of injury:						
Years of education completed:						
Age:						
Gender: M / F / Other						
Dominant hand: left / neither / right						
How many diagnosed concussions has the athlete had in the past?:						
When was the most recent concussion?						
How long was the recovery (time to being cleared to p from the most recent concussion?:		(days)				
Has the athlete ever been:						
Hospitalized for a head injury?	Yes	No				
Diagnosed / treated for headache disorder or migraines?	Yes	No				
Diagnosed with a learning disability / dyslexia?	Yes	No				
Diagnosed with ADD / ADHD?						
Diagnosed with depression, anxiety or other psychiatric disorder?	Yes	No				
Current medications? If yes, please list:						

	-
Name:	
DOB:	_34
Address:	
ID number:	
Examiner:	2.3
Date:	176

Pressure in head* 0 1 2 3 4 5 6 Neck Page 0 1 2 3 4 5 6 Nausea or vomiting 0 1 2 3 4 5 6 Sturred vision 0 1 2 3 4 5 6 Sturred vision 0 1 2 3 4 5 6 Sturred vision 0 1 2 3 4 5 6 Sturred vision 0 1 2 3 4 5 6 Stephing slowed down 0 1 2 3 4 5	Please Check: 🗆 Ba	sellne 🗆) P	ost-li	njury			
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