joint PHYSIOTHERAPY

shift CONCUSSION MANAGEMENT PROGRAM

Athlete Name: ______________________________________ Date of Birth:____/____/______(dd/mm/yy)

Age: ________ Height: _____/_____(ft/in) Weight _______ lbs

Parent Name: __________________________ Phone: ______________________

Team Name (if applicable): ____

CONFIDENTIAL MEDICAL INFORMATION AND CONCUSSION HISTORY

Please complete the following questions as fully and carefully as possible in order to help us effectively interpret the results of your baseline assessment. This information will remain strictly confidential.

Concussion History: include month/year, how it happened, symptoms experienced, and length of recovery:

☐No known concussions

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Do any of the following conditions apply? (Please indicate)

☐ADD/ADHD ☐Clinical Depression/Anxiety ☐Migraine Headaches ☐Learning Disability ☐Sleep Disorder

☐Dyslexia ☐Repeated one or more grade levels ☐Received speech therapy

☐Individual Education Plan (IEP) ☐Motion Sickness / Car Sickness ☐Visual Condition: _________________

Please indicate your level of academic performance:

☐Below average (C/D Student) ☐Average (B/C Student) ☐Above Average (A/B Student)

PLEASE REVIEW BELOW, SIGN, AND RETURN

I hereby consent to the administration and supervision of a concussion baseline test by Joint Physiotherapy. I understand that baseline testing does not prevent concussive injuries, but allows healthcare professionals to better manage the injury should it occur.

_____________________________ _____________________________ _____________________________

SIGNED PRINT NAME DATE

For Athletes under the age of 16: PLEASE HAVE PARENT/GUARDIAN SIGN ABOVE*