University of Florida Interdisciplinary Concussion/TBI Clinic

If someone else helped you fill out this questionnaire, check here_____ and indicate who provided help_____

INFORMATION ABOUT YOU

Last Name (current)_____ First Name (current)_____

Have you had a legal name change since birth: ☐Yes ☐No (if Yes, complete questions below)

Last Name (at birth)_____ First Name (at birth)_____

Country of Birth ☐ USA Other_____ City and State of Birth _____

Biological Sex: ☐Male ☐Female Handedness ☐Left ☐Right ☐Ambidextrous

Ethnicity

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Unknown

Race

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ African America/Black
- ☐ Caucasian/White

PRIMARY PROBLEMS AND COMPLAINTS

Please describe the primary problems (symptoms, concerns) you currently experience:

_____

_____

_____

HEADACHE

Have you had one or more headaches (unrelated to alcohol/substance use) in the past 3 months? ☐Yes ☐No

If Yes, did light bother you (more than when you don't have a headache)? ☐Yes No

If Yes, did you get nauseous or sick to your stomach? ☐Yes ☐No

If you have headaches, how often do they occur? _____ What is their usual severity (0-10)? _____

If you have daily/frequent low-grade headaches, how often do they suddenly worsen?_____

Do you take medications for headache? If so, what medications? _____

Have you received prior treatment for headaches? ☐Yes ☐No (describe)_____

Headache Impact: If you have headaches, circle one answer for each of the following questions:

When you have headaches, how often is the pain severe?	Never Often	Rarely	Sometimes	Very Often
How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?	Never Often	Rarely	Sometimes	Very Often
When you have a headache, how often do you wish you could lie down?	Never Often	Rarely	Sometimes	Very Often
In the past **4 weeks**, how often have you felt too tired to do work or daily activities because of your headaches?	Never Often	Rarely	Sometimes	Very Often
In the past **4 weeks**, how often have you felt fed up or irritated because of your headaches?	Never Often	Rarely	Sometimes	Very Often
In the past **4 weeks**, how often did headaches limit your ability to concentrate on work or daily activities?	Never Often	Rarely	Sometimes	Very Often

ACADEMIC AND OCCUPATIONAL HISTORY

What is the highest grade/degree that you have completed? (circle one)
1 2 3 4 5 6 7 8 9 10 11 12th/ HS Diploma GED Some College Associate's Bachelor's Master's Doctorate (s): _____

Year of high school graduation (expected) _____ High school city & state _____

Type of student: ☐ Above Average ☐ Average ☐ Below Average High School GPA if applicable_____☐ 4.0 ☐ 5.0 ☐0-100%

College(s) Attended _____ From _____(year) to _____(year)

_____ From _____(year) to _____ (year)

Graduate School _____ From _____ (year) to _____ (year)

Did you ever skip a year/grade of school? ☐Yes ☐No

If Yes, what grade(s)?_____

Have you ever repeated a year of school? ☐Yes ☐No

If Yes, what grade(s)? _____

Prior to college, have you ever received school mandated academic assistance (e.g. tutoring or extended test time)?
☐Yes ☐No

Prior to college, have you had an:
-Individualized Education Plan (IEP) ☐Yes ☐No
-504 Plan ☐Yes ☐No
-Other assistance ☐Yes ☐No
If Yes to any , in what areas: ☐ Reading ☐ Writing
☐ Math ☐ Other_____

What is your current occupation? _____

Are you currently retired? ☐Yes ☐No
Are you currently receiving disability?, ☐Yes ☐No
Have you, or are you, applying for disability? ☐Yes ☐No

Describe previous occupations/jobs, starting with the most recent.
_____
_____
_____

OTHER - This information helps us estimate your pre-injury capabilities and characteristics

Estimated income of your family of **origin** **(mother/father)**
☐ $0-30,000 ☐ $30,001-60,000 ☐ $60,001-90,000 ☐ $90,001-120,000 ☐ $120,001-150,000
☐ $150,001-180,000 ☐ $180,001-210,000 ☐ $210,001-240,000 ☐ $240,001 -$270,000 ☐ $270,001- $300,000
☐ +$300,001 ☐ Unknown ☐ Prefer not to answer

Mother/Guardian 1 Highest Level of Education
☐Unknown ☐K-7th grade ☐8th – 9th grade ☐Partial High School (10th or 11th grade)
☐High School Graduate ☐Partial College (at least 1 year) ☐College Degree ☐Graduate Degree

Mother/Guardian 1 Occupation (*if retired/ deceased, choose profession held throughout most working years*)
☐Unknown/Unemployed
☐Farm/day laborer
☐Unskilled/service worker
☐Machine operator, semi-skilled worker
☐Skilled manual worker, craftsman, police/fire, enlisted/non-commissioned officer
☐Clerical/sales, small farm owner
☐ Technician, semiprofessional, supervisor, office manager
☐ Small business owner, farm owner, teacher, low level manager, salaried worker
☐ Mid-level manager or professional (ex: architect, engineer, accountant, attorney), mid-sized business owner, military officer
☐ Senior manager or professional (ex: physician, college professor, minister), owner or CEO of large business

Father/ Guardian 2 Highest Level of Education
☐Unknown ☐K-7th grade ☐8th – 9th grade ☐Partial High School (10th or 11th grade)
☐High School Graduate ☐Partial College (at least 1 year) ☐College Degree ☐Graduate Degree

Father/Guardian 2 Occupation (*if retired/deceased, choose profession held throughout most working years*)
☐Unknown/Unemployed
☐Farm/day laborer
☐Unskilled/service worker
☐Machine operator, semi-skilled worker
☐Skilled manual worker, craftsman, police/fire, enlisted/non-commissioned officer
☐Clerical/sales, small farm owner
☐ Technician, semiprofessional, supervisor, office manager
☐ Small business owner, farm owner, teacher, low level manager, salaried worker
☐ Mid-level manager or professional (ex: architect, engineer, accountant, attorney), mid-sized business owner, military officer
☐ Senior manager or professional (ex: physician, college professor, minister), owner or CEO of large business

CONCUSSION HISTORY

Definition of Concussion: A change in brain function following a force to the head, which may be accompanied by temporary loss of consciousness, but is identified in awake individuals with measures of neurologic and cognitive dysfunction. Common concussion symptoms include:

- Headache
- Feeling slowed down
- Difficulty concentrating or focusing
- Dizziness, balance problems, loss of balance
- Feeling in a fog
- Irritable
- Drowsiness
- Nausea
- Forgetting things (before or after the injury)
- Sensitivity to light/noise
- Blurred vision
- Fatigue/lack of energy

IMPORTANT: A) A concussion can occur without being "knocked out" or unconscious B) getting your "bell rung" and "clearing the cobwebs" is a concussion

Have you ever had a concussion or mTBI related to sport or other activities? ☐ Yes ☐ No If yes, how many previous concussions have you had? _____

	Sport or Non-Sport Related Concussion	Was the concussion formally diagnosed by a health professional?	Approximate date of injury (mm/yyyy)	Age at time of injury	Did you lose consciousness (i.e. knocked out/blacked out)?	How long were you unconsciousness (seconds)?	Did/do you have difficulty remembering things before or after the injury?	How many minutes do you not remember (min)	How many days did you experience symptoms related to the injury? If you are still experiencing symptoms, write "Now"
Injury #1	☐Sport ☐Non-Sport	☐ Yes ☐ No	_____/_____		☐Yes ☐No	_____(sec) ☐ Unknown	☐Yes ☐No	_____(min) ☐ Unknown	_____(days) ☐ Unknown
Injury #2	☐Sport ☐Non-Sport	☐ Yes ☐ No	_____/_____		☐Yes ☐No	_____(sec) ☐ Unknown	☐Yes ☐No	_____(min) ☐ Unknown	_____(days) ☐ Unknown
Injury #3	☐Sport ☐Non-Sport	☐ Yes ☐ No	/_____		☐Yes ☐No	_____(sec) ☐ Unknown	☐Yes ☐No	_____(min) ☐ Unknown	_____(days) ☐ Unknown
Injury #4	☐Sport ☐Non-Sport	☐ Yes ☐ No	_____/_____		☐Yes ☐No	_____(sec) ☐ Unknown	☐Yes ☐No	_____(min) ☐ Unknown	_____(days) ☐ Unknown
Injury #5	☐Sport ☐Non-Sport	☐ Yes ☐ No	/_____		☐Yes ☐No	_____(sec) ☐ Unknown	☐Yes ☐No	_____(min) ☐ Unknown	_____(days) ☐ Unknown
Injury #6	☐Sport ☐Non-Sport	☐ Yes ☐ No	_____/_____		☐Yes ☐No	_____(sec) ☐ Unknown	☐Yes ☐No	_____(min) ☐ Unknown	_____(days) ☐ Unknown
Injury #7	☐Sport ☐Non-Sport	☐ Yes ☐ No	/_____		☐Yes ☐No	_____(sec) ☐ Unknown	☐Yes ☐No	_____(min) ☐ Unknown	_____(days) ☐ Unknown
Injury #8	☐Sport ☐Non-Sport	☐ Yes ☐ No	_____/_____		☐Yes ☐No	_____(sec) ☐ Unknown	☐Yes ☐No	_____(min) ☐ Unknown	_____(days) ☐ Unknown
Injury #9	☐Sport ☐Non-Sport	☐ Yes ☐ No	/_____		☐Yes ☐No	_____(sec) ☐ Unknown	☐Yes ☐No	_____(min) ☐ Unknown	_____(days) ☐ Unknown
Injury #10	☐Sport ☐Non-Sport	☐ Yes ☐ No	_____/_____		☐Yes ☐No	_____(sec) ☐ Unknown	☐Yes ☐No	_____(min) ☐ Unknown	_____(days) ☐ Unknown

MEDICAL HISTORY	
For **every** condition below, have **you or a family member (circle)** ever been diagnosed by a Physician/MD with:	
Heart disease	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
High Blood Pressure	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Diabetes:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
High Cholesterol:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Cancer	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Lung Disease	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Asthma	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Kidney failure	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Thyroid disease	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Headache (non-migraine):	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Migraine	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Meningitis/Brain Infection:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Seizure Disorder/Epilepsy:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Sleep Disorder:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Balance Disorder	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
If yes, what was/is the diagnosis	☐ Vestibular Disorder ☐ Vertigo ☐ Motion Sickness ☐ Meniere's Disease ☐
Psychiatric Disorder:	You: ☐Yes ☐No | Family Member: ☐Yes ☐No
If yes, what was/is the diagnosis	☐Unknown ☐Mood Disorder (Excluding depression and bipolar disorder) ☐Anxiety Disorder ☐PTSD ☐Somatoform Disorder ☐Alcohol Abuse ☐Drug Abuse ☐Personality Disorder ☐Psychotic Disorder (Excluding schizophrenia) ☐
Learning Disorder (e.g. dyslexia):	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Attention Deficit-Hyperactivity Disorder (ADD/ADHD):	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Autism Spectrum Disorder:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Depression:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Bipolar Disorder:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Schizophrenia:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Moderate/Severe Traumatic Brain Injury:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Brain Surgery:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Vision Problems (other than glasses/contacts):	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Hearing Problems:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Stroke:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Parkinson's Disease:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Memory Disorder:	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Dementia (Alzheimer's disease)	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Dementia (non-Alzheimer's)	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent
Mild Cognitive Impairment (MCI)	You: ☐Yes ☐No | Mother Father Sister Brother Grandparent

MEDICATIONS, DRUGS, AND HEALTH HABITS

Are you currently taking prescription medications? ☐Yes ☐ No

If Yes, check all that apply: ☐ Antidepressants ☐ Anti-anxiety ☐ Anti-psychotic ☐ Narcotic pain medication ☐ Non-narcotic pain medication ☐ Sleep aid/sedative ☐ Psychostimulant ☐ Birth Control ☐ Allergy ☐ Asthma ☐ Acid Reflux/heart burn ☐ Anticonvulsants ☐ Other(s)_____

If you indicated yes to any of the above, please provide the name(s) and dosages_____
_____

Are you taking over-the-counter medications (eg Advil/Ibuprofen, Claritin, etc) ☐Yes ☐No

If yes, check all that apply: ☐ Advil/Ibuprofen ☐ Tylenol/Acetaminophen ☐ Claritin / Allergy medication ☐ Other_____

Are you taking over-the-counter supplements (eg protein or vitamins)? ☐Yes ☐No

If yes, check all that apply: ☐ Protein ☐Creatine ☐ DHEA ☐Chromium ☐Androstenedione ☐Vitamins ☐Weight loss ☐ Other_____

Have you ever undergone surgery with general anesthesia? ☐Yes ☐No

If yes, describe _____

If yes, did you have any anesthesia complications? ☐Yes ☐No

If yes, describe_____

Have you used nicotine products (e.g. smoked, dipped, vaped) in the past month ☐Yes ☐No

Type of nicotine product used ☐Cigarettes ☐Cigars ☐Smokeless tobacco/dip ☐Vape ☐ Gum/patch

If yes, how many cigarettes/cigars per day?_____Cans of dip per day?_____

Have you used marijuana in the past month ☐Yes ☐No

If yes, how much per week?_____

Have you used alcohol in the past month? ☐Yes ☐No

If yes, estimate the number of days per week over the last month you drank _____

On those days, what is the average number of drinks you consumed? _____

Do you drink caffeinated beverages (coffee, soda)? ☐Yes ☐No

Approximately how many caffeinated beverages do you drink per day? _____

Describe your exercise habits_____

Have these habits changed following your injury? ☐Yes ☐No

Number of days per week I get some exercise_____ Number of minutes per day _____

SLEEP

Have your sleep patterns changed since your injury? ☐Yes ☐No If "yes", describe _____

_____

Number of hours (current average) per night on weekdays_____ Weekends_____

Indicate your "ideal" number of hours of sleep per night _____ Do you have daytime sleepiness? ☐Yes ☐No

Do you have trouble falling asleep? ☐Yes ☐No

Do you wake up in the middle of the night? ☐Yes ☐No If yes, how many times per night? _____

List factors that may be interfering with your sleep (e.g., pain, worry, medications/drugs, etc.) _____

_____

Have you ever been diagnosed with a sleep disorder? ☐Yes ☐No If yes, what was the diagnosis? _____

_____

Have you received prior treatment for sleep problems? ☐No ☐Yes (describe) _____

_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in **recent times.**

Even if you haven't done some of these things recently try to work out how they would have affected you.

Place a checkmark for the most appropriate number for each situation:

Situation:	0 = Would **never** doze	1 = **Slight chance** of dozing	2 = **Moderate chance** of dozing	3 = **High chance** of dozing
Sitting and reading:				
Watching TV:				
Sitting, inactive in a public place (e.g., a theatre or a meeting):				
Lying down to rest in the afternoon when circumstances permit:				
Sitting and talking to someone				
Sitting Quietly after a lunch without alcohol:				
In a car, while stopped for a few minutes in the traffic:				

FATIGUE RATING

On a 0 (extremely exhausted) to 100 (completely awake and alert) scale how have you USUALLY felt since your injury? _____

On the same scale, how do you FEEL NOW? _____

If Your Injury is <u>NOT</u> Sports-Related (And you have NO sports-related concussion history), Stop

You have completed the questionnaire. Please bring the completed questionnaire with you to your visit.

If Your Injury **<u>IS</u>** Sports-Related Please **Continue to the Next Page**

Information for Sports Participation

ORGANIZED SPORTS HISTORY-Primary Sport			
Check your current athletic level below and your primary sport(s) to the right: _____Retired Professional _____Active Professional _____Former College/University _____Active College/University _____High School _____Recreational/Intramural	___Baseball ___Basketball ___Bowling ___Cheerleading ___CC/Track ___Diving ___Fencing ___Field Event	___Field Hockey ___Football ___Golf ___Gymnastics ___Ice Hockey ___Lacrosse ___Rifle ___Rowing/Crew	___Skiing ___Soccer ___Softball ___Swimming ___Tennis ___Volleyball ___Volleyball-Beach ___Water Polo ___Wrestling
What is your primary position in your sport?_____ **Position on depth chart: □ 1st string □ 2nd string □ 3rd string □ Other**			
How many years have you participated in your primary sport? _____ years			
Counting only organized games/events, estimate percent of time you were in the active lineup _____%			
ORGANIZED SPORTS HISTORY – Secondary Sport			
***Other than your primary sport,* indicate the number of years you participated in any of the following organized sports**	___Baseball ___Basketball ___Bowling ___Cheerleading ___CC/Track ___Diving ___Fencing ___Field Event	___Field Hockey ___Football ___Golf ___Gymnastics ___Ice Hockey ___Lacrosse ___Rifle ___Rowing/Crew	___Skiing ___Soccer ___Softball ___Swimming ___Tennis ___Volleyball ___Volleyball-Beach ___Water Polo ___Wrestling
ORGANIZED SPORTS HISTORY – Protective Equipment			
I wear protective equipment (helmet, mouthguard, pads) when participating in my sport □ Yes □ No			
If you answered "yes" to the previous question, indicate what type(s) of protective equipment you use: _____ _____			
ORGANIZED SPORTS HISTORY – Participation in Concussion Management Protocols			
Does your school/organization provide baseline concussion testing? □ Yes □ No			
Have you participated in baseline concussion testing? □ Yes □ No □ Not available			
Have you ever been asked to take concussion testing after an injury? □ Yes □ No □ Not available			
If you have taken computerized concussion testing, what is the name of the test _____ **Approximate date of most recent testing _____** **Number of times you have taken computerized concussion testing _____**			
Have you ever had to participate in a graduated return-to-play protocol after suffering a concussion? **□ Yes □ No □ Not available If so, how many times_____**			