# FOLLOW UP CONCUSSION FORM

**Organization: _____ Athlete's Name:_____**

**Athlete's D.O.B. :_____ Athlete's Parent/Guardian:_____**

**Injury Date/Time:_____ Sport/Activity:_____**

**Concussion Team Leader:_____ Athlete's PCP:_____**

**Concussion symptom score:_____ Date concussion score was obtained:_____**

**<u>To the athlete's Medical Care Provider</u>: The athlete named above has suffered a presumed concussion and is now enrolled in the concussion management protocol (a copy of which can be found under the "resources" tab of www.concussionconsultants.org) but may not return to ANY athletic activity (practice, games, contact drills) until cleared by a qualified medical provider. Qualified medical providers may include an M.D., D. O., Nurse Practitioner or Physician Assistant. After your evaluation, please check which option or options you would now recommend:**

**____Start this student athlete on the graduated exercise program as detailed in the concussion management protocol. At any stage, if the student has any increased post concussive symptoms with exertion, he or she must be taken back to the previous stage of graduated exercise for at least 24 hours. If the athlete has any persistent post concussive symptoms that are worsening, that athlete will be returned to medical personnel for re-evaluation and will not be allowed to return to the graduated exercise program until cleared by qualified medical personnel to do so.**

**_____No physical exertion until the next clinic visit scheduled for_____**

**_____Academic accommodations including decreased amount of homework, testing, etc. until_____**

**_____Additional recommendations:**

**This athlete may start on the graduated exercise program as of (date): _____**

**Name of Qualified Medical Provider (please print): _____**

**Signature of Qualified Medical Provider: _____**

**Title of Qualified Medical Provider (please circle one): M.D. D.O. P.A. N.P.**

**Phone number of Qualified Medical Provider: _____Date of evaluation:_____**

**SEVERITY RATING**

Please use this scale to rate each symptom.

| None | Mild | | Moderate | | Severe | |
|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |

PATIENT'S NAME:_____

# POST-CONCUSSION SYMPTOM SCALE

| Symptoms | Date: | Date: | Date: | Date: | Date: | Date: | Date: |
|---|---|---|---|---|---|---|---|
| Headache | | | | | | | |
| Nausea | | | | | | | |
| Vomiting | | | | | | | |
| Balance Problems | | | | | | | |
| Dizziness (spinning or movement sensation) | | | | | | | |
| Lightheadedness | | | | | | | |
| Fatigue | | | | | | | |
| Trouble falling asleep | | | | | | | |
| Sleeping more than usual | | | | | | | |
| Sleeping less than usual | | | | | | | |
| Drowsiness | | | | | | | |
| Sensitivity to light | | | | | | | |
| Sensitivity to noise | | | | | | | |
| Irritability | | | | | | | |
| Sadness | | | | | | | |
| Nervous/Anxious | | | | | | | |
| Feeling more emotional | | | | | | | |
| Numbness or tingling | | | | | | | |
| Feeling slowed down | | | | | | | |
| Feeling like "in a fog" | | | | | | | |
| Difficulty concentrating | | | | | | | |
| Difficulty remembering | | | | | | | |
| Visual problems | | | | | | | |
| Other | | | | | | | |
| **Total** | | | | | | | |