

**CSCC New Injury Intake Form**

**Provider** \_\_\_\_\_ **Arrival time** \_\_\_\_\_

**Name:** \_\_\_\_\_ **ID #: A** \_\_\_\_\_ **Date of Service:** \_\_\_\_\_

**School/Occupation:** \_\_\_\_\_ **Sport/Position:** \_\_\_\_\_ **Date of Injury:** \_\_\_\_\_

**PMH:** None ADD/ADHD Migraines Seizures Motion Sickness Anxiety/psychiatric hx **ED Referral:** No Yes \_\_\_\_\_

**Referral Source/Pediatrician:** \_\_\_\_\_ **Medications:** \_\_\_\_\_

**Location of Impact:** \_\_\_\_\_ **LOC:** No Yes Duration \_\_\_\_\_

**Previous Concussions:** No Yes **Details (dates, duration of symptoms, time missed, etc):** \_\_\_\_\_

**History/comments:** \_\_\_\_\_

**% of nl today:** \_\_\_\_\_

**SYMPTOM CHECKLIST**

Has the patient experienced any of these symptoms any more than usual *today* or in the *past day*?  
Check Yes / No and rate severity of symptoms (0 = None, 1= Mild, 3= Moderate, 6 = Severe)

	Y	Severity 0-6	N		Y	Severity 0-6	N
Headache				Confused			
Nausea				Irritable			
Vomiting				Sad			
Balance problems				Nervous			
Dizziness				Emotional			
Fatigue				Numbness/Tingling			
Trouble falling asleep				Slowed Down			
Sleeping more than usual				Mentally Foggy			
Sleeping less than usual				Difficulty concentrating			
Drowsiness				Difficulty remembering			
Sensitive to light				Vision problems			
Sensitive to noise				Neck Pain			
Feeling anxious				Tinnitus			

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**Describe "Yes" Answers:** \_\_\_\_\_

**Neurocognitive Baseline?** \_\_\_\_\_

**VS Results (circle results)**

H Test: WNL Nystagmus Sxes/dizzy/blurry \_\_\_\_\_  
 Horizontal Saccades: WNL Under/over shoot Sxes/dizzy/blurry \_\_\_\_\_  
 Vertical Saccades: WNL Under/over shoot Sxes/dizzy/blurry \_\_\_\_\_  
 Horizontal Gaze Stability: WNL Nystagmus Sxes/dizzy/blurry Hang time/slow \_\_\_\_\_  
 Vertical Gaze Stability: WNL Nystagmus Sxes/dizzy/blurry Hang time/slow \_\_\_\_\_  
 Accomodation Insufficiency: \_\_\_\_\_ cm \_\_\_\_\_  
 Convergence Insufficiency: \_\_\_\_\_ cm \_\_\_\_\_  
 Balance WNL Excessive Sway Unable to sustain x 30 seconds \_\_\_\_\_  
 Runway Walk WNL Sxes/dizzy/blurry \_\_\_\_\_

**Worth 4-Dot Test**

Subjective Description \_\_\_\_\_  
 Green moving Yes No Red moving Yes No \_\_\_\_\_

**Vision Screen (if indicated)** Corr/Uncorr RE: \_\_\_\_/20 LE: \_\_\_\_/20 BE: \_\_\_\_/20

**Returning to School/Work**

Cleared to return to school / work without restrictions.

Not cleared to return to school / work until further notice.

Return to school/work with following supports on (date) \_\_\_\_\_.

Shortened day. Recommend \_\_\_\_\_ until (date) \_\_\_\_\_.

Allow extra time to complete tasks.

Lessen work/homework load to allow adequate cognitive rest.

Work \_\_\_\_ minutes with intervals of \_\_\_\_\_ minute breaks (total \_\_\_\_ hours)

No significant classroom or standardized testing at this time.

Patient is to limit any cognitive stimulants including: driving, watching television/movies, listening to music, reading, cell phone usage, gaming devices, etc to ensure strict cognitive rest.

Activity \_\_\_\_ minutes with intervals of \_\_\_\_ minute breaks (total \_\_\_\_ hours)

Take rest breaks during the day as needed. Check for the return of symptoms (use symptom list on Concussion Care Plan Packet) when participating in activities requiring a significant amount of attention or concentration.

Additional instructions: \_\_\_\_\_.

**Returning to Physical Activity**

Cleared to fully return to physical activity participation without restriction.

Not cleared for physical activity at this time (includes PE class, sport practices/games, weight training, etc).

Gradual return to physical activity under the supervision of a physician and/or athletic trainer:

Once asymptomatic for 24 hours, patient may start (stage) \_\_\_\_\_ of CFPSM's (sport) \_\_\_\_\_ Exercise Progression Protocol. This is to be monitored by: \_\_\_\_\_.

May start (stage) \_\_\_\_\_ of CFPSM's (sport) \_\_\_\_\_ Exercise Progression Protocol. This is to be monitored by \_\_\_\_\_.

Patient is not cleared for full contact, physical education class, or unsupervised physical activity while participating in CFPSM's Exercise Progression. Check for return of symptoms (use symptom list on Concussion Care Plan Packet) when participating in activity and 24 hours following. Call our office for further recommendations if symptoms return.

Additional Instructions: \_\_\_\_\_.

**Follow-up**

Follow-up on (date/stage of RTP) \_\_\_\_\_.

F/U OV to include:  Vestibular Screen       Worth 4 Dot Test       ImPACT or Concussion Vital Signs

Referral to: Neurology \_\_\_\_\_ Optometry \_\_\_\_\_ Neuropsychology \_\_\_\_\_ Vestibular Therapy \_\_\_\_\_  
Hyperbarics \_\_\_\_\_ Nutritionist \_\_\_\_\_ Physical Therapy \_\_\_\_\_ Psychiatrist \_\_\_\_\_