CONFLUENCE WELLNESS CENTER, PC

Allen Berger, DC
Matrix Repatterning, Chiropractic, Acupuncture, Nutrition, NET

303-394-4204 1776 South Jackson St., Ste. 418, Denver, CO 80210

POST- CONCUSSION ASSESSMENT

Name: _____ Date:_____

Injury Date:_____ Date of Birth:_____

Reporter:☐ Patient ☐ Parent ☐ Spouse Other_____

Description of Injury:

Cause: ☐Motor Vehicle Crash ☐Ped-Motor Vehicle ☐Fall ☐ Sports ☐ Assault ☐Other

Was your head hit on the: ☐Top ☐Forehead ☐ Left Side ☐ Right Side ☐Back ☐Face

Were there any events just before the injury that you have no memory of (even briefly)?
☐Yes ☐ No Duration_____

Were there any events just after the injury that you have no memory of (even briefly)?
☐Yes ☐No Duration_____

Did you lose consciousness (even briefly)?
☐Yes ☐No Duration_____

Overall do your symptoms worsen with:	
Physical Activity	☐Yes ☐No ☐ NA
Mental Activity	☐Yes ☐No ☐ NA
Work	☐Yes ☐No ☐ NA
School	☐Yes ☐No ☐ NA
Reading or Visual Activity	☐Yes ☐No ☐ NA

Symptoms – More than usual since injury
Please circle the appropriate number on all questions 0=none 1=mild 2=moderate 3=severe

PHYSICAL	
Headache	0 1 2 3
Neck Pain	0 1 2 3
Other Pain: Describe	0 1 2 3
Numbness/Tingling	0 1 2 3
Restlessness	0 1 2 3
Weakness	0 1 2 3
Fatigue	0 1 2 3
Nausea	0 1 2 3
Vomiting	0 1 2 3
Seizures	0 1 2 3

Total _____

STABILITY	
Clumsiness	0 1 2 3
Balance Problems	0 1 2 3
Dizziness	0 1 2 3
Falling	0 1 2 3

Total _____

EMOTIONAL	
Irritability	0 1 2 3
Sadness	0 1 2 3
Nervousness/Anxiety	0 1 2 3
Feeling Frustrated	0 1 2 3
Mood Swings	0 1 2 3

Total _____

COGNITIVE	
Feeling Foggy	0 1 2 3
Feeling Slowed Down	0 1 2 3
Difficulty Concentrating	0 1 2 3
Difficulty Remembering	0 1 2 3
Difficulty Speaking	0 1 2 3

Total _____

SENSATIONS	
Visual Problems	0 1 2 3
Hearing Problems	0 1 2 3
Problems with Smell/Taste	0 1 2 3
Sensitivity to Light	0 1 2 3
Sensitive to Noise	0 1 2 3
Sensitivity to Smells/Taste	0 1 2 3

Total _____

SLEEP	
Drowsiness	0 1 2 3
Sleeping Less Than Usual	0 1 2 3
Sleeping More Than Usual	0 1 2 3
Trouble Falling Asleep	0 1 2 3
Trouble Staying Asleep	0 1 2 3

Total _____

Grand Total

_____

Are you experiencing any other **new difficulties?** Please describe and rate as above.

1. _____ 0 1 2 3
2. _____ 0 1 2 3
3. _____ 0 1 2 3

Complicating Factors

Have you had previous concussions? ☐Yes ☐No How many?_____
How long did your previous symptoms persist? _____
Did it take less force to cause reinjuries this time? ☐Yes ☐No
Have you had problems with headaches prior to your head injury? ☐Yes ☐ No