



Baseline Worksheet

I. Demographic and Background Information

School / Organization: _____

Date of Birth: _____ month _____ date _____ year

First Name: _____ Last Name: _____

Height: _____ ft _____ in Weight: _____ Gender: _____ male _____ female

Handedness: _____ right _____ left _____ ambidextrous (both right and left)

Native Country / Region: _____

Native Language: _____

Second Language: _____ (only if fluent in speaking and writing)

Years of education completed excluding kindergarten: _____

(e.g., high school senior is 11 years)

Check any of the following that apply:

- _____ Received speech therapy
- _____ Attended special education classes
- _____ Repeated one or more years of school
- _____ Diagnosed attention deficit disorder or hyperactivity
- _____ Diagnosed learning disability

While in school, what type of student were / are you?

_____ Below Average _____ Average _____ Above Average

Current Sport: _____

Current position / event / class: _____

(e.g., quarterback, forward, 1st base, etc.)

Current level of participation: _____ (e.g., junior high, high school)

Years of experience at this level: _____ (0 - 4)

(e.g., number of years in high school, high school senior = 3)

Please list your 5 most recent concussions:

_____	month	_____	year
_____	month	_____	year
_____	month	_____	year
_____	month	_____	year
_____	month	_____	year

Concussion History

- _____ Number of times diagnosed with a concussion (excluding current injury)
- _____ Total number of concussions
- _____ Total number of concussions that resulted in confusion
- _____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately after injury
- _____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately before injury
- _____ Total number a games that were missed as a direct result of all concussions combined

I. Demographic and Background Information (cont.)

Baseline Worksheet

Indicate if you have had any of the following:

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Treatment for headaches by physician |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Treatment for migraine headaches by physician |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Treatment for epilepsy / seizures |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Treatment for brain surgery |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Treatment for meningitis |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Treatment for substance abuse / alcohol abuse |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Treatment for psychiatric condition (depression, anxiety) |

Have you been diagnosed with any of the following?

- | | | |
|------------------------------|-----------------------------|-----------|
| <input type="checkbox"/> yes | <input type="checkbox"/> no | ADD/ ADHD |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Dyslexia |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Autism |

Have you participated in any strenuous exercise and/or exertion in the last 3 hrs?

yes no

Date of your last concussion: _____ month _____ date _____ year

Number of hours slept last night: _____ (approximate if uncertain)

Please list any **PRESCRIPTION** medication (s) you are currently taking:
