Baylor Scott & White Family Medicine Keller Concussion Program

Patient Name: _____ Date of Evaluation: _____

The Athlete named above is cleared for a complete return to full contact sport participation:

- As of _____
- When they have completed the tasks noted below* without symptoms.

The Athlete is instructed to stop play immediately and notify the coach or athletic trainer should his/ her symptoms return or if they should become symptomatic with any additional contact.

*Additional Note:

Signature _____ Date: _____

Jason Wander DO, Primary Care Sports Medicine Physician, Certified Impact Consultant

Baylor Scott & White Family Medicine Keller

Clinic Number: 817-912-8150

Baylor Scott & White Family Medicine Keller Concussion Program

Follow- up Interview

Name/ ID: _____ Date of last Evaluation: _____

Date of Evaluation: _____ Date of Concussion: _____

Previous Symptoms **Present Symptoms**

	Yes	No	Duration/Description		Yes	No	Description
Headache	__/10		Top RF LF RT LT RO LO Gen Hrs Trob/Press/Dull Worse in AM / PM Worse w/ cog / phys exert		__/10		Top RF LF RT LT RO LO Gen Hrs Trob/Press/Dull Worse in AM / PM Worse w/ cog / phys exert
Nausea			hrs				hrs
Vomiting			hrs				hrs
Dizziness			hrs				hrs
Motor Problem			hrs				hrs
Fatigue			hrs				hrs
Visual Changes			hrs				hrs
Sensitivity to Light			hrs				hrs
Sensitivity to Noise			hrs				hrs
Emotionality			hrs				hrs
Irritability			hrs				hrs
Fogginess			hrs				hrs
Attn/Concentration			hrs				hrs
Short Term Memory			hrs				hrs
Slowed Down			hrs				hrs
Hyposomnia			hrs				hrs
Hypersomnia			hrs				hrs
Drowsiness			hrs				hrs
Other: Neck Pain/Ears Ringing			hrs				hrs

Interim Medical History:

New injuries? New medications? Diagnostics?

Other Follow –up Notes:

Post- injury Exertional Activity:

(SX worse with exertion?)

Cognitive: School Work/ Job/Computer/Other stress:

(SX worse with exertion?) (Grades dropped?)