ADVANCE
PHYSICAL THERAPY

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Concussion Screening Protocol

Patient Name:		Date:	
Assessor:			

Pre-Screening Questions

Did you get direct blow to head?	☐ Yes ☐ No
Location of Impact:	☐ Frontal ☐ Lt Temporal ☐ Rt Temporal ☐ Lt Parietal ☐ Rt Parietal ☐ Occipital ☐ Neck ☐ Indirect Force
Cause:	☐ MVA ☐ Pedestrian-MVA ☐ Fall d) Assault ☐ Sports (specify)____________________ ☐ Other:______________________
Anterograde Amnesia:	Are there any events just after the injury that you have no or distorted memory of? ☐ Yes ☐ No
Retrograde Amnesia:	Are there any events just before the injury that you have no or distorted memory of? ☐ Yes ☐ No
Loss of Consciousness?	☐ Yes ☐ No
Seizures:	Were seizures observed? ☐ Yes ☐ No Detail: ____

Symptom Check List

Physical symptoms

☐ Headache ☐ Nausea/ Vomiting ☐ Balance Problems ☐ Dizziness ☐ Visual Problems
☐ Fatigue ☐ Light Sensitivity ☐ Noise Sensitivity ☐ Numbness/Tinglings

Cognitive symptoms

☐ Feeling mentally foggy ☐ Feeling slowed down ☐ Difficulty concentrating ☐ Difficulty remembering

Emotional symptoms

☐ Irritability ☐ Sadness ☐ Aggression ☐ More emotional
☐ Nervousness ☐ Less tolerance to stress

Sleep changes

☐ Drowsiness ☐ Sleep disturbances ☐ Behavioral changes

Reference:

Gioia G, Collins M. Acute concussion evaluation (Ace) Patient Name: Physician/clinician office version. www.cdc.gov/headsup/pdfs/providers/ace-a.pdf. Accessed Apr 10, 2019.

Signature: ____