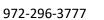


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<b>Concussion Screening F</b>	Protocol		
Patient Name:		Date:	
Assessor:	'		
Pre-Screening Questions			
Did you get direct blow to head?	☐ Yes ☐ No		
Location of Impact:	☐ Frontal ☐ Lt Temporal ☐ ☐ Rt Parietal ☐ Occipital ☐	Rt Temporal	
Cause:		Fall d) Assault	
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 of? $\square$ Yes $\square$ No	that you have no or distorted memory	
Loss of Consciousness?	☐ Yes ☐ No		
Seizures:	Were seizures observed? ☐ Yes Detail:	□ No	
Symptom Check List			
Physical symptoms			
<ul><li>☐ Headache</li><li>☐ Nausea/ Vomitin</li><li>☐ Fatigue</li><li>☐ Light Sensitivity</li></ul>	g □ Balance Problems □ Dizziness □ Noise Sensitivity □ Numbness/T		
Cognitive symptoms			
$\square$ Feeling mentally foggy $\square$ Fee	ling slowed down 🛛 Difficulty concentrati	ng 🔲 Difficulty remembering	
<b>Emotional symptoms</b>			
-	Aggression		
Sleep changes			
☐ Drowsiness ☐ Sleep dis	turbances		
Reference:			
	n evaluation (Ace) Patient Name: Physician/cl ers/ace-a.pdf. Accessed Apr 10, 2019.	linician office version.	

Signature: \_\_\_