515 Chiropractic and 515 Softwave Regeneration- Personal Injury

(20-25 minutes)
1239 73rd Street, Des Moines, IA 50324 515-274-4444

Name:_____ **Date of Birth:** _____ **Date:**_____
Sex: ____ **Height:**_____ **Weight:**_____ ☐**Single** ☐**Married** **Children:**_____
Mobile #:_____ **Work#:** _____ **Home #:** _____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Email:_____ **How did you hear about our office?**_____
Employer:_____ **Duties:**_____
Emergency Contact:_____ **Relationship:**_____ **Phone:**_____

(IF YOU WERE IN A CAR ACCIDENT PLEASE DON'T FILL THIS SECTION: COMPLETE "PERSONAL INJURY INTAKE" FORM)

Primary Complaint/Pain:_____ **2nd Complaint/Pain:**_____ **3rd:**_____
Describe the pain you are experiencing: (Check ALL that apply)
☐Mild ☐Mild to Moderate ☐Moderate ☐Moderate to Severe ☐Severe ☐Constant
☐Frequent ☐Intermittent ☐Occasional ☐Random ---------- ☐Tightness ☐Stiffness ☐Sharp ☐Dull ☐Aching ☐Numbness
☐Tingling ☐Throbbing ☐Anguish ☐Burning ☐Continuous ☐Deep ☐Depression ☐Despair ☐Discomfort ☐Insidious ☐Intense
☐Malaise ☐Melancholy ☐Self-loathing ☐Shooting ☐Superficial
Rate the level of your pain on a scale of 1-10: (Circle)
(Very Little) 1-------2-------3-------4-------5-------6-------7-------8-------9-------10 (worst pain you have felt)
How frequent/percentage of the time do you feel the pain? (Circle)
0%-------10%-------20%-------30%-------40%-------50%-------60%-------70%-------80%-------90%-------100%

When did you first notice the pain? (Date)_____ What caused the pain?_____
Does the pain radiate/Travel? ☐Shoulder ☐Arm ☐Leg → ☐Front ☐Back ☐Side ☐Other/More:_____
Have you had this symptoms before? Yes/No Date: _____ **Are your symptoms getting:** (Circle) Better/Worse/Same
What aggravates the pain? (Check ALL that apply) ☐Medications ☐Bending ☐Twisting ☐Lying down ☐Sitting
☐Sitting to standing ☐Standing ☐Walking ☐Almost any movement ☐Reaching ☐Exercise ☐Bowling ☐Carrying
☐Cleaning ☐Climbing ☐Cooking ☐Coughing ☐Crawling ☐Cycling ☐Dressing ☐Driving ☐Eating ☐Gardening
☐Heat ☐Ice ☐Jumping ☐Kneeling ☐Lifting ☐Golf ☐Tennis ☐Pulling ☐Pushing ☐Resting ☐Running ☐Sex
☐Sleeping ☐Sliding ☐Sneezing ☐Stooping ☐Swinging ☐Turning ☐Typing ☐Work ☐Other:_____
What makes it improved? (Check ALL that apply) ☐Nothing ☐Chiropractic ☐Ice ☐Medications ☐Bending ☐Twisting
☐Lying down ☐Sitting ☐Sitting to standing ☐Standing ☐Walking ☐Almost any movement ☐Reaching ☐Exercise
☐Bowling ☐Carrying ☐Cleaning ☐Climbing ☐Cooking ☐Coughing ☐Crawling ☐Cycling ☐Dressing ☐Driving
☐Eating ☐Gardening ☐Heat, ☐Ice ☐Jumping ☐Kneeling ☐Lifting ☐Golf ☐Tennis ☐Pulling ☐Pushing ☐Resting
☐Running ☐Sex ☐Sleeping ☐Sliding ☐Sneezing ☐Stooping ☐Swinging ☐Turning ☐Typing ☐Work ☐Other:_____
What is your health history? ☐Stroke ☐Arthritis ☐High Blood pressure ☐Digestive problems ☐Depression ☐Cancer
☐Other:_____

Family History: Father: ☐Stroke ☐Arthritis ☐High Blood pressure ☐Digestive problems ☐Cancer ☐Other:_____
Mother: ☐Stroke ☐Arthritis ☐High Blood pressure ☐Digestive problems ☐Depression ☐Cancer ☐Other:_____
Ethnicity: ☐Indian/Alaskan Native ☐Asian ☐Black/African American ☐White(Caucasian) ☐Pacific Islander
☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Decline --- **List Allergies:**_____
Please list current medications and Purpose: ☐_____ ☐_____
☐_____ ☐_____ ☐_____

Insurance company: Primary:_____ **Secondary:**_____
Auto Accident or Workers Compensation Claim #:_____ **Date of Injury:**_____

I certify that I am the patient or guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of this information in this office.

Patient's/Guardian's Signature_____ Date:_____

515 Chiropractic and 515 SoftWave Regeneration

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

X-ray Release

This is to certify that the Doctor at 515 Chiropractic has my permission to perform an X-ray evaluation. To the best of my knowledge I am not pregnant and I have been advised that x-ray can be hazardous to an unborn child.

Consent to Care for Minor

I authorize the doctors at 515 Chiropractic and whomever he may designate as his assistant to administer care as he so deems necessary to my son/daughter.

Insurance

I understand that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that the doctors at 515 Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctors at 515 Chiropractic will be credited to my account on receipt. Your insurance company will only pay for services that they determine are medically necessary. I understand that some or all services provided for me might not be covered by my contract benefits. I understand that all services rendered me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my care, any fees for services rendered me will be immediately due and payable.

I have read and understand the above and I agree to these policies and procedures.

☐ **Terms of Acceptance** ☐ **Patient Health Information Consent Form** ☐ **X-ray Release** ☐ **Minor Consent** ☐ **Insurance**

Signature: _____ **Date:** _____

515 Chiropractic and 515 SoftWave Regeneration- Personal Injury Intake

Date of accident:_____ Name:_____ Today's Date_____

Mechanism of injury- ☐Rear ended ☐Rear driver's side ☐Rear passenger side ☐Drivers side ☐Passenger side ☐Front driver side ☐Front passenger side ☐Struck another vehicle

Where were you in the Vehicle: ☐Driver ☐Front passenger ☐Rear passenger

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Were the police on scene of the accident: (circle) YES / NO **Did EMS show up on the scene:** (circle) YES / NO

Was a police report filed? (circle) YES / NO **Were you wearing a seatbelt?** (circle) YES / NO

What directions were you facing during accident?

☐Forward ☐Slightly right ☐Slightly left ☐Looking down ☐Looking back right ☐Looking back left

Did any part of your body make contact with the inside of the vehicle?

☐Head ☐Left arm ☐Right arm ☐Right leg/knee ☐Left leg/knee ☐Left hand ☐Right hand

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Your (patient) vehicle travel speed? ☐Stopped ☐Moving forward slowly (0-10mph)

☐Moving forward at mild speed (11-25mph) ☐Moving forward at moderate speed (26-45mph)

☐Moving forward at high speed (45+mph) ☐Turning right ☐Turning left ☐Backing up

Other vehicle traveling? ☐Stopped ☐Moving forward slowly (0-10mph)

☐Moving forward at mild speed (11-25mph) ☐Moving forward at moderate speed (26-45mph)

☐Moving forward at high speed (45+mph) ☐Turning right ☐Turning left ☐Backing up

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Your (patient) Vehicle damage- ☐Mild ☐Mild to Moderate ☐Moderate ☐Moderate to Severe, ☐Severe ☐Totaled

The Other Vehicles damage was: ☐Mild ☐Mild to Moderate ☐Moderate ☐Moderate to Severe, ☐Severe ☐Totaled

Did you require hospitalization? (circle) YES / NO

Did you lose any days from work? (circle) YES / NO

List ALL areas you experiencing discomfort? _____

Were any of these areas pre-existing conditions before the accident? NO / YES, (list) _____

Describe the pain you are experiencing: (Check ALL that apply)

☐Mild ☐Mild to Moderate ☐Moderate ☐Moderate to Severe ☐Severe ☐Constant

☐Frequent ☐Intermittent ☐Occasional ☐Random---------- ☐Tightness ☐Stiffness ☐Sharp ☐Dull ☐Aching

☐Numbness ☐Tingling ☐Throbbing ☐Anguish ☐Burning ☐Continuous ☐Deep ☐Depression ☐Despair ☐Discomfort

☐Insidious ☐Intense ☐Malaise ☐Melancholy ☐Self-loathing ☐Shooting ☐Superficial

Rate the level of your pain on a scale of 1-10: (Circle)

(Very Little) 1-------2-------3-------4-------5-------6-------7-------8-------9-------10 (worst pain you have felt)

How frequent/percentage of the time do you feel the pain? (Circle)

0%-------10%-------20%-------30%-------40%-------50%-------60%-------70%-------80%-------90%-------100%

Are your symptoms getting: (Circle) Better - Worse - Staying the same

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What aggravates the pain? (Check ALL that apply) ☐Medications ☐Bending ☐Twisting ☐Lying down ☐Sitting

☐Sitting to standing ☐Standing ☐Walking ☐Almost any movement ☐Reaching ☐Exercise ☐Bowling ☐Carrying

☐Cleaning ☐Climbing ☐Cooking ☐Coughing ☐Crawling ☐Cycling ☐Dressing ☐Driving ☐Eating ☐Gardening

☐Heat ☐Ice ☐Jumping ☐Kneeling ☐Lifting ☐Golf ☐Tennis ☐Pulling ☐Pushing ☐Resting ☐Running ☐Sex

☐Sleeping ☐Sliding ☐Sneezing ☐Stooping ☐Swinging ☐Turning ☐Typing ☐Work

What makes it better? (Check ALL that apply) ☐Nothing ☐Chiropractic ☐Ice ☐Medications ☐Bending ☐Twisting

☐Lying down ☐Sitting ☐Sitting to standing ☐Standing ☐Walking ☐Almost any movement ☐Reaching ☐Exercise

☐Bowling ☐Carrying ☐Cleaning ☐Climbing ☐Cooking ☐Coughing ☐Crawling ☐Cycling ☐Dressing ☐Driving

☐Eating ☐Gardening ☐Heat, ☐Ice ☐Jumping ☐Kneeling ☐Lifting ☐Golf ☐Tennis ☐Pulling ☐Pushing ☐Resting

☐Running ☐Sex ☐Sleeping ☐Sliding ☐Sneezing ☐Stooping ☐Swinging ☐Turning ☐Typing ☐Work

Page 43 Appendix 3-1 Pain Disability Questionnaire
Page 600, Figure 17-A Pain Disbaility Questionnaire (PDQ)

Patient Name:_____ Date:_____

Instructions: These questions ask for your views about how your pain now affects your function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
(Work Normally) (Unable to work at all)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
(Take care of Self completely) (Need help with all my personal care)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

3. Does your pain interfere with your traveling?
(Travel anywhere I like) (Only travel to see the doctor)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

4. Does your pain affect your ability to sit or stand?
(No problems) (Cannot sit/stand at all)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
(No problems) (Cannot do at all)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
(No problems) (Cannot do at all)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

7. Does your pain affect your ability to walk or run?
(No problems) (Cannot walk or run at all)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

8. Has your income declined since your pain began?
(No decline) (Lost all income)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

9. Do you have to take pain medication every day to control your pain?
(No medications needed) (On pain medication throughout the day)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

10. Does your pain force you to see doctors much more often than before your pain began?
(Never see doctors) (See doctors weekly)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
(No problem) (Never see them)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
(No interference) (Total interference)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
(Never need help) (Need help all the time)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
(No depression/tension) (Severe depression/tension)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

15. Are there emotional problems caused by your pain that interfere with your family, social, an/or work activities?
(No problems) (Severe problems)
0--------1-------2-------3-------4------5-------6-------7-------8-------9-------10

Add up for TOTAL SCORE:_____

(Circle) Total score	**0**	**1-70**	**71-100**	**101-130**	**131-150**
Impairment:	**0%**	**0%**	**1%**	**2%**	**3%**

Anagnostis,C. Gatchel RJ, Mayer TG. The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculosketetal Disorders. Spine 2004; 29 (20): 2290-2302

515 Chiropractic and 515 SoftWave Regeneration

Back Disability Questionnaire

Name:		Age:		Date:	

Section 1- Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

Section 2- Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

Section 3- Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if conveniently positioned.
F. I can only lift very light weights, at the most.

Section 4- Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

Section 5- Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me sitting more than 1 hour.
D. Pain prevents me sitting more than ½ hour.
E. Pain prevents me sitting more than 10 minutes.
F. Pain prevents me sitting at all.

Section 6- Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

Section 7- Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

Section 8- Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

Section 9- Traveling

A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

Section 10- Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

515 Chiropractic and 515 SoftWave Regeneration Neck Disability Questionnaire					
Name:		Age:		Date:	
SECTION 1 – Pain Intensity A. I have no pain at the moment. B. The pain is very mild at the moment. C. The pain is moderate at the moment. D. The pain is fairly severe at the moment. E. The pain is very severe at the moment. F. The pain is worst imaginable at the moment.		**SECTION 6 – Concentration** A. I can concentrate fully when I want to with no difficulty. B. I can concentrate fully when I want to with slight difficulty. C. I have a fair degree of difficulty in concentrating when I want to. D. I have a lot of difficulty in concentrating when I want to. E. I have a great deal of difficulty in concentrating when I want to. F. I cannot concentrate at all.			
SECTION 2 – Personal Care A. I can look after myself normally without causing extra pain. B. I can look after myself normally, but it causes extra pain. C. It is painful to look after myself and I am slow and careful. D. I need some help, but manage most of my personal care. E. I need help every day in most aspects of self care. F. I do not get dressed; I wash with difficulty and stay in bed.		**SECTION 7 - Work** A. I can do as much work as I want to. B. I can only do my usual work, but no more. C. I can do most of my usual work, but no more. D. I cannot do my usual work. E. I can hardly do any work at all. F. I cannot do any work at all.			
SECTION 3 – Lifting A. I can lift heavy weights without extra pain. B. I can lift heavy weights but it gives me extra pain. C. Pain prevents me from lifting heavy weights off the floor. D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. F. I can only lift very light weights, at the most.		**SECTION 8 –Driving** A. I can drive without any neck pain. B. I can drive as long as I want with slight pain in my neck. C. I can drive as long as I want with moderate pain in my neck. D. I cannot drive as long as I want because of moderate pain in my neck. E. I can hardly drive at all because of severe pain in my neck. F. I cannot drive at all.			
SECTION 4 – Reading A. I can read as much as I want to with no pain in my neck. B. I can read as much as I want to with slight pain in my neck. C. I can read as much as I want to with moderate pain in my neck. D. I cannot read as much as I want because of moderate pain in my neck. E. I cannot read as much as I want because of severe pain in my neck. F. I cannot read at all.		**SECTION 9 - Sleeping** A. I have no trouble sleeping. B. My sleep is slightly disturbed (less than 1 hr sleepless). C. My sleep is mildly disturbed (1-2 hours sleepless). D. My sleep is moderately disturbed (2-3 hours sleepless). E. My sleep is greatly disturbed (3-5 hours sleepless). F. My sleep is completely disturbed (5-7 hours).			
SECTION 5 - Headaches A. I have no headaches at all. B. I have slight headaches which come infrequently. C. I have moderate headaches which come infrequently. D. I have moderate headaches which come frequently. E. I have severe headaches which come frequently. F. I have headaches almost all the time.		**SECTION 10 – Recreation** A. I am able to engage in all of my recreational activities with no neck pain at all. B. I am able to engage in all of my recreational activities with some pain in my neck. C. I am able to engage in most, but not all of my recreational activities because of pain in my neck. D. I am able to engage in a few of my recreational activities because of pain in my neck. E. I can hardly do any recreational activities because of pain in my neck. F. I cannot do any recreational activities at all.			

ACUTE CONCUSSION EVALUATION (ACE)

Physician/Clinician Office Version

Gerard Gioia, PhD[1] & Micky Collins, PhD[2]
[1]Children's National Medical Center
[2] University of Pittsburgh Medical Center

Patient Name_____
DOB: _____ Age:_____
Date:_____ ID/MR#_____

A. Injury Characteristics **Date/Time of Injury**_____ **Reporter: __Patient __Parent __Spouse __Other**_____

1. Injury Description _____

_____

1a. Is there evidence of a forcible blow to the head (direct or indirect)? __Yes __No __Unknown
1b. Is there evidence of intracranial injury or skull fracture? __Yes __No __Unknown
1c. Location of Impact: __Frontal __Lft Temporal __Rt Temporal __Lft Parietal __Rt Parietal __Occipital __Neck __Indirect Force

2. Cause: __MVC __Pedestrian-MVC __Fall __Assault __Sports (specify)_____Other_____

3. Amnesia Before (Retrograde) Are there any events just BEFORE the injury that you/ person has no memory of (even brief)? __ Yes __No Duration_____

4. Amnesia After (Anterograde) Are there any events just AFTER the injury that you/ person has no memory of (even brief)? __ Yes __No Duration_____

5. Loss of Consciousness: Did you/ person lose consciousness? __ Yes __No Duration_____

6. EARLY SIGNS: __Appears dazed or stunned __Is confused about events __Answers questions slowly __Repeats Questions __Forgetful (recent info)

7. Seizures: Were seizures observed? No__ Yes___ Detail_____

B. Symptom Check List* Since the injury, has the person experienced any of these symptoms any more than usual today or in the past day?

Indicate presence of each symptom (0=No, 1=Yes). ***Lovell & Collins, 1998 JHTR***

PHYSICAL (10)		COGNITIVE (4)		SLEEP (4)		
Headache	0 1	Feeling mentally foggy	0 1	Drowsiness	0 1	
Nausea	0 1	Feeling slowed down	0 1	Sleeping less than usual	0 1	N/A
Vomiting	0 1	Difficulty concentrating	0 1	Sleeping more than usual	0 1	N/A
Balance problems	0 1	Difficulty remembering	0 1	Trouble falling asleep	0 1	N/A
Dizziness	0 1	**COGNITIVE Total (0-4)** _____		**SLEEP Total (0-4)** _____		
Visual problems	0 1	**EMOTIONAL (4)**				
Fatigue	0 1	Irritability	0 1			
Sensitivity to light	0 1	Sadness	0 1			
Sensitivity to noise	0 1	More emotional	0 1			
Numbness/Tingling	0 1	Nervousness	0 1			
PHYSICAL Total (0-10) _____		**EMOTIONAL Total (0-4)** _____				
(Add Physical, Cognitive, Emotion, Sleep totals) Total Symptom Score (0-22) _____						

Exertion: Do these symptoms worsen with:
Physical Activity __Yes __No __N/A
Cognitive Activity __Yes __No __N/A

Overall Rating: How different is the person acting compared to his/her usual self? (circle)
Normal 0 1 2 3 4 5 6 Very Different

C. Risk Factors for Protracted Recovery (check all that apply)

Concussion History? Y ___ N___	√	Headache History? Y ___ N___	√	Developmental History	√	Psychiatric History
Previous # 1 2 3 4 5		Prior treatment for headache		Learning disabilities		Anxiety
Longest symptom duration Days__ Weeks__ Months__ Years__		History of migraine headache __ Personal __ Family_____		Attention-Deficit/ Hyperactivity Disorder		Depression
						Sleep disorder
If multiple concussions, less force caused reinjury? Yes__ No__				Other developmental disorder_____		Other psychiatric disorder _____

List other comorbid medical disorders or medication usage (e.g., hypothyroid, seizures)_____

_____

D. RED FLAGS for acute emergency management: Refer to the emergency department with sudden onset of any of the following:

*** Headaches that worsen**	*** Looks very drowsy/ can't be awakened**	*** Can't recognize people or places**	*** Neck pain**
***Seizures**	*** Repeated vomiting**	*** Increasing confusion or irritability**	*** Unusual behavioral change**
*** Focal neurologic signs**	*** Slurred speech**	*** Weakness or numbness in arms/legs**	*** Change in state of consciousness**

E. Diagnosis (ICD-10): __Concussion w/o LOC S06.0X0A __Concussion w/ LOC S06.0X1A __Concussion (Unspecified) S06.0X9A __Other (854)_
__No diagnosis

F. Follow-Up Action Plan **Complete *ACE Care Plan* and provide copy to patient/family.**

___ **No Follow-Up Needed**
___ **Physician/ Clinician Office Monitoring**: Date of next follow-up _____
___ **Referral:**
___ Neuropsychological Testing
___ Physician: Neurosurgery____ Neurology____ Sports Medicine____ Physiatrist____ Psychiatrist____ Other_____
___ Emergency Department

ACE Completed by:_____ **MD DC RN NP PhD ATC**