



ImPACT™
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Baseline Worksheet

I. Demographic and Background Information

General Information

Name _____ DOB _____

ID# _____ Height _____ Weight _____

School/ Organization: North Hunterdon High School, Annandale NJ 08801

Handedness: R or L or Both Gender: Male or Female

Language

Native Language _____

Education

Years of Education Completed (e.g., high school senior is 11 years) _____ 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

Sports

Current Sport: _____

position/ event/ class _____

level of participation _____

(e.g.: high school, semi-professional, collegiate etc)

years of experience at this level: _____

(approximate if needed; e.g., high school senior is 3 years)

Concussion History

Number of times diagnosed with a concussion: _____

Total number of concussions that have resulted in loss of consciousness

- Total number of concussions that resulted in confusion.
- Total number of concussions that resulted in difficulty with memory of events occurring immediately after injury.
- Total number of concussions that resulted in difficulty with memory of events occurring immediately before injury.
- Total number of games that were missed as a result of concussions

Please List your five most recent concussions: _____
(use approximate dates if needed) _____

Indicate whether you have experienced 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 | History of brain surgery |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | History of meningitis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treatment for substance/ alcohol abuse |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treatment for psychiatric condition (depression, anxiety etc.) |