RUTGERS New Jersey Medical School

[Healthcare facility name]
90 Bergen st, DOC 810
Newark, NJ 07103
973-972-5337

Post Concussion Patient Intake Form

Please take a few minutes to fill out this form so that we can provide you with the **best medical care.** Rutgers NJMS welcomes your feedback and your answers will be kept confidential

Demographic Information

Name:_____ Date of birth: _____ Age:_____

Home Address: _____

Home phone: _____ Cell phone: _____

Email: _____

Care Information – Please list complete name and address of physicians (VERY IMPORTANT)

Primary Care Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ fax: _____ Email: _____

Referring Physician (if different from PCP): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ fax: _____ Email: _____

Pharmacy: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ fax: _____

Reason for Visit – Chief Complaint (History of Present Illness)

On a scale of 0-6 please rate the following symptoms:

Symptom	none	Mild		moderate		severe	
Headache	0	1	2	3	4	5	6
Pressure in the head	0	1	2	3	4	5	6
Neck pain	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"don't feel right"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigued or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or anxious	0	1	2	3	4	5	6

List past and present medications that you have taken for your symptoms

Name:	dosage:	effect on symptoms:

Is this visit related to worker's compensation? (circle one) YES NO

Is this visit related to ANY legal actions? (circle one) YES NO

If this problem is a result of an accident, when did the accident occur? _____

Surgical History Please list all operation you have had:	**Date:**

Medical History Please list all active medical conditions:	**Duration:**

Please list all **MEDICAITONS** you take on a regular basis, prescribed or over the counter

Medication:	Dose:	Frequency

Please LIST all ALLERGIES and sensitivities (medications, food, latex, iodine, etc.)

_____

Social History

Job: _____ Marital status:_____ number of children:____

Hobbies_____

Do you smoke cigarettes?_____ If so, how many packs a day?:_____

At what age did you start?_____ What age did you stop_____

Do you drink alcohol (beer, wine, gin, ect.)?_____if yes, how much daily?_____

At what age did you start?_____ When did you stop?_____

Do you use any recreational drugs (marijuana, cocaine, ect)? _____ If so, what type?_____

Do you exercise regularly (circle one): YES NO

Family history: Do you have a family member with:

Condition	Yes	No	type/affected relative	Condition	Yes	No	type/affected relative
Brain Tumor	☐	☐		Muscle Disease	☐	☐	
Seizures or Epilepsy	☐	☐		Neuropathy	☐	☐	
Dementia	☐	☐		Other Neurological Disorder	☐	☐	
Parkinson's	☐	☐		Hypertension	☐	☐	
Multiple Sclerosis	☐	☐		Diabetes	☐	☐	
Thyroid Disease	☐	☐		Migraines	☐	☐	

Write other conditions _____

Review of Symptoms: Do you currently, or have you had a problem with:

Constitutional:	***Circle One***	
Fever	Yes	No
Weight loss >5 lbs	Yes	No
Excessive fatigue	Yes	No
History of Falls	Yes	No
Eyes:		
Wear glasses	Yes	No
Infections	Yes	No
Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Ear, Nose, Throat & Mouth:		
Wear hearing aid(s)	Yes	No
Hearing loss	Yes	No
Ear pain/infections	Yes	No
Ringing in ears	Yes	No
Nose bleeds	Yes	No
Nasal congestion/drainage	Yes	No
Inability to smell	Yes	No
Sinus problems	Yes	No
Balance (vertigo, spinning, etc.)	Yes	No
Cardiovascular:		
Chest pain or angina	Yes	No
High blood pressure	Yes	No
Irregular pulse	Yes	No
Heart murmur	Yes	No
High cholesterol	Yes	No
Swelling in hands or feet	Yes	No
Leg pain while walking	Yes	No
Respiratory:		
Asthma	Yes	No
Emphysema	Yes	No
Shortness of breath	Yes	No
Pneumonia	Yes	No
Bloody sputum	Yes	No
Gastrointestinal:		
Nausea	Yes	No
Vomiting	Yes	No
Blood in your vomit	Yes	No
Liver disease	Yes	No
Jaundice	Yes	No
Abdominal pain	Yes	No
Change in bowel habits	Yes	No
Ulcers or gastritis	Yes	No

Endocrine:	***Circle One***	
Diabetes	Yes	No
Thyroid disease	Yes	No
Excessive thirst/urination	Yes	No
Genitourinary:		
Urinary tract infections	Yes	No
Painful urination	Yes	No
Blood in your urine	Yes	No
Difficult starting/stopping stream	Yes	No
Incontinence	Yes	No
Kidney stones	Yes	No
Musculoskeletal:		
Broken bones	Yes	No
Arm or leg weakness	Yes	No
Arm or leg pain	Yes	No
Joint pain or swelling	Yes	No
Arthritis	Yes	No
Integumentary:		
Skin disease	Yes	No
Breast pain, tenderness, nipple discharge	Yes	No
Unusual moles	Yes	No
Neurological:		
Fainting spells or "black outs"	Yes	No
Headaches	Yes	No
Seizures	Yes	No
Problems with memory	Yes	No
Disorientation	Yes	No
Difficulty with speech	Yes	No
Inability to concentrate	Yes	No
Double or blurred vision	Yes	No
Weakness in arms and/or legs	Yes	No
Loss of sensation	Yes	No
Difficulty with balance	Yes	No
Psychiatric:		
Anxiety	Yes	No
Depression	Yes	No
Hematologic/Lymphatic:		
Anemia	Yes	No
Hemophilia	Yes	No
Blood transfusion	Yes	No
Persistent swollen glands/lymph nodes	Yes	No
HIV	Yes	No
Allergic/Immunologic:		
Food, Inhalant (nasal) allergies	Yes	No
Autoimmune disease (i.e., lupus)	Yes	No

Handedness

Are you (circle one): **RIGHT HANDED** **LEFT HANDED**

This Information on this form is accurate to the best of my knowledge:

_____ _____

Patient Signature Date completed

I have reviewed the above information with the patient

_____ _____

Physician Signature Date reviewed