BioFXN
Personalized Innovative Healthcare

Dr. Anna Martin, ND
Functional Medicine Doctor *Powered by Rebound SportsMed*

Name: _____

Date:_____Age: _____

Concussion/Mild Traumatic Brain Injury Intake Form

Please provide us with some information about your injury, if you do not understand a question, your therapist will assist you during the evaluation.

Date/Time of Injury:_____**Injury description**: _____

_____

1b. Location of Impact: On the head- ☐ Front ☐ Left Front ☐ Right Front ☐ Left Back ☐ Right Back ☐ Back
Other location- ☐ Neck ☐ Body

2. Cause: ☐ Car accident ☐ Hit by a car ☐ Fall ☐ Assault ☐ Sports (specify)_____ ☐ Other _____

3. Are there any events just BEFORE the injury that you have no memory of (even brief)? ☐ Yes ☐ No Duration_____

4. Are there any events just AFTER the injury that you have no memory of (even brief)? ☐ Yes ☐ No Duration_____

5. Did you lose consciousness? ☐ Yes ☐ No Duration_____

6. Early Signs: ☐ Dazed or stunned ☐ Confused about events ☐ Slow to respond ☐ Dizzy ☐ Forgetful ☐ Repeating things

7. Were seizures observed? ☐ Yes ☐ No If **yes**, please provide details_____

8**. Did you receive medical attention at the time of the injury?** ☐ Yes ☐ No If **yes**, please explain, including any tests & results:

_____

Since the injury, have you experienced any of these symptoms more than usual **today** or **in the past day**?

☐ Headache ☐ Fatigue ☐ Difficulty Concentrating ☐ Drowsiness ☐ Sleeping more than usual ☐ Nausea

☐ Sensitivity to light ☐ Difficulty remembering ☐ Trouble falling asleep ☐ Sleeping less than usual ☐ Vomiting

☐ Sensitivity to noise ☐ Irritability

☐ Balance Problems ☐ Numbness/tingling ☐ Sadness

☐ Dizziness ☐ Feeling mentally foggy ☐ More emotional

☐ Visual Problems ☐ Feeling slowed down ☐ Nervousness

Exertion: Do these symptoms worsen with:
Physical Activity ☐ Yes ☐ No ☐ N/A
Concentration/thinking ☐ Yes ☐ No ☐ N/A

Has anything like this ever happened in the past? ☐ Y ☐ N
If yes, how many times? 1 2 3 4 5 6+
What's the longest you experienced symptoms? ☐ Days ☐ Weeks ☐ Months ☐ Years

Vision	Headache (HA)	Developmental	✓	Psychiatric	✓
History of vision change or disturbance? ☐ Y ☐ N	Prior treatment for HA? ☐ Y ☐ N	Learning disabilities		Anxiety	
If yes, please explain: _____	History of migraine headache	ADD/ADHD		Depression	
_____	☐ Personal ☐ Family	Other Developmental Disorder_____		Sleep Disorder	
	_____			Other psychiatric disorder	

How do you learn best? By:
☐ Hearing it ☐ Reading it ☐ Seeing it demonstrated ☐ Performing it yourself ☐ Observing someone else

Rate your **average pain** or symptom on a scale of 0-10 with **"0" equals to no pain** and **"10" equals the worst imaginable.**
→ Mark the line at the point that represents your pain or symptom.

0 | | | | | | | | | | 10
1 2 3 4 5 6 7 8 9

Rate how near you are to your **normal function** on a scale of 0-10 by with **"0" equals not able** to perform ***any*** of your normal activities and "**10" equals able** to do ***all*** normal activities without difficulty. → Mark the line at the point that represents your level of function.

0 | | | | | | | | | | 10
1 2 3 4 5 6 7 8 9

Which skills or abilities do you hope to regain by coming to therapy? _____

***PLEASE CONTINUE ON THE OTHER SIDE ***

Which of the following **over the counter medications** are you taking or have taken in the last week?

☐ Ibuprofen (Advil) ☐ Antihistamines ☐ Decongestants ☐ Naturopathic ☐ Vitamins ☐ Antacids
☐ Aspirin ☐ Laxatives ☐ Tylenol ☐ Naproxen Sodium (Aleve) ☐ Other: _____

Which of the following **prescription medications** are you taking?

☐ Allergy ☐ Hormones ☐ Pain ☐ Tone/Spasticity Reduction ☐ Other:_____
☐ Antibiotic ☐ Diabetes ☐ Reflux ☐ Cholesterol_____
☐ Anti-inflammatory ☐ Depression ☐ Seizure ☐ Thyroid
☐ Blood Pressure ☐ Respiratory ☐ Anti-nausea ☐ Bladder
☐ Heart ☐ Muscle Relaxant ☐ Blood Thinners ☐ MS Med/Fatigue

Medical History:

☐ ADD/AHD
☐ Amputation
☐ Autism
☐ Auto Immune Disease:_____
☐ Balance Problems
☐ Bowel/Bladder Problems
☐ Cancer: _____
☐ Cardiac Condition: _____
☐ Chemical Dependency
☐ Chronic Otitis Media
☐ Cleft Palate
☐ Dementia
☐ Depression
☐ Diabetes
☐ Dizziness
☐ DVT's
☐ Failure to Thrive
☐ Falls
☐ Feeding/Swallowing Problems
☐ Fibromyalgia
Fractures: _____
☐ Gastrointestinal: _____
☐ Hepatitis
☐ Hearing Loss
☐ Headaches/Migraines
☐ High Blood Pressure (Hypertension)
☐ Labor/Delivery Complication
☐ Neurological Condition: _____
☐ Noise Exposure
☐ Osteoarthritis
☐ Osteoporosis
☐ Psychological Condition: _____
☐ Respiratory Condition: _____
☐ Rheumatoid Arthritis
☐ Seizures
☐ Sleep disturbances
☐ Thyroid
☐ TMJ
☐ Vision
☐ Voice
☐ Other: _____

Do you have any known allergies: Drug_____ Other _____

Social History:

1. Support system
   ☐ Married ☐ Single ☐ Widowed ☐ Significant other: _____
2. Living arrangement:
   ☐ Home/alone ☐ Home w/family ☐ Assisted living center ☐ Adult Foster home
   ☐ Children at home #:_____ Ages of Children_____
3. Amount of help currently needed at home:
   ☐ None ☐ Part of the day ☐ During the day ☐ During the night ☐ 24 hours a day
4. Home Accessibility:
   ☐ # of Stairs/Steps ☐ Walk-in Shower ☐ Rail ☐ Tub/shower combination
5. Assistive Devices/Equipment:
   ☐ Cane ☐ Bath bench ☐ Resting splints ☐ Walker ☐ Brace
   ☐ Raised toilet seat ☐ Commode ☐ Prosthesis ☐ Wheelchair/scooter ☐ Grab bars
   ☐ Hospital bed ☐ Dressing equipment ☐ Hearing aids ☐ Glasses ☐ Lifeline

Work History: Occupation:_____

Current Status? ☐ Full duty ☐ Temporary disability ☐ Permanent disability ☐ Applied for disability

☐ Retired ☐ Volunteer ☐ Light duty ☐ Modified duty/job

☐ Restrictions are: _____

☐ Anticipated **return to work** date or work status change? _____

Physician follow-up: ☐ Physician recheck is scheduled for this date: _____