Intake Form for Clients with Concussion Symptoms

Date: _____

CLIENT DOCUMENTATION

Client Name:	Age:	Occupation:	Gender: ☐ F ☐ M
Dominant Hand: ☐ L ☐ R	Able to read? ☐ Y ☐ N		Able to view screens? ☐ Y ☐ N
Physician:	Able to work/study? ☐ Y ☐ N		Authorized to drive? ☐ Y ☐ N
Neurologist:	When did you last pass out?		Do you have seizures? ☐ Y ☐ N

Contact Information

Phone #	☐ Work	Email:
	☐ Home	Home Address:

Health History

Do you have a learning disability/dyslexia/ ADD/ADHD?	☐ Y ☐ N	Details:
Have you ever been diagnosed with depression, anxiety, or other psychiatric disorder?	☐ Y ☐ N	If yes, was this before any concussions? ☐ Y ☐ N
Has anyone in your family ever been diagnosed with any of these problems?	☐ Y ☐ N	
Did you have headaches & migraines prior to any concussions?	☐ Y ☐ N	Details:

Concussion History

Previous Concussions

# of concussions prior to this one:

Date of concussion prior to this one?

Were symptoms 100% resolved from the concussion prior to this one?	☐ Y ☐ N	
If yes, how long did recovery take?		
If no, what were the ongoing symptoms?		
Were you able to work/study after the *previous* concussion?	☐ Y ☐ N ☐N/A	How long were you off?

Describe therapies/treatments undertaken:	Duration:	Effectiveness:
1.	1.	1.
2.	2.	2.
3.	3.	3.

Current Concussion

Date of most recent concussion:

Describe how it happened & other injuries, if applicable:

Were you hospitalized?	☐ Y ☐ N	Duration:
Medical imaging of head?	☐ Y ☐ N	Results/Diagnosis:

Area(s) of brain affected: ☐ Left Front ☐Left Side ☐ Left Back ☐ Top ☐ Mid-brain ☐ Right Front ☐ Right Side ☐ Right Back

Other physical injuries?	☐ Y ☐ N	Details:
Are you on medication(s)?	☐ Y ☐ N	List:

Describe current therapies/treatments:

Assessment adapted from the SCAT3 Sport Concussion Assessment Tool

Assessment # ___ Client: _____ Date: _____

Bowenwork Practitioner: **Madeline McBride** ☐ Self-rated ☐ Interview

1. Symptom Evaluation	None	Mild		Moderate		Severe	
Date:	0	1	2	3	4	5	6
Headache							
Neck pain							
Pressure in head							
Pain in _____							
Numbness/Tingling in _____							
Nausea or vomiting							
Poor appetite							
Dizziness							
Balance problems							
Blurred vision							
Sensitivity to light							
Double vision or other issues							
Hearing impairment							
Sensitivity to noise							
Ringing in ears/tinnitus							
Feeling “slowed down”							
Feeling “in a fog”							
“Don’t feel right”							
Feeling restless							
Difficulty concentrating							
Difficulty remembering							
Forgetful							
Confusion							
Fatigue or low energy							
Drowsiness							
Difficulty falling asleep							
Difficulty staying asleep (e.g., pain)							
Easily annoyed or irritable							
Feeling sad, depressed or tearful							
Feeling nervous or anxious							
Other symptoms							
Total # of symptoms							
Symptom Severity Score							
Do the symptoms get worse with physical activity?			☐ Y ☐ N				
Do the symptoms get worse with mental activity?			☐ Y ☐ N				

Regarding ability to do physical activities, how well can you perform today?

☐ Can do vigorous exercise ☐ Can do mild exercise ☐ Can walk ☐ Cannot be active because _____ (reason)

Regarding ability to read on screens, how well can you perform today?

☐ Can view all screens ☐ Can view screens for _____ (length of time) ☐ Cannot view screens today because _____

hours you sleep per night: ____ # hours you sleep during the day: _____