Ridgefield Pediatric Associates, P.C.
ImPACT Testing Questionnaire

Section I

Please answer the following general questions about your child.

Name: Age:

Date of Birth: Height (ft and in):

Gender: Weight:

Handedness:

Native Country/Region: Second Language:

Native Language: Years Speaking:

Years of Education Completed Excluding Kindergarten: Repeated One or More Years of School:

Received Speech Therapy: Diagnosed Learning Disability:

Attended Special Education Classes: Problems with ADD/Hyperactivity:

What Type of Student (circle one):
Average Above Average Below Average

Current Sport: Current Level of Participation:

Primary Position/Event/Class: Years of Experience at this Level:

Section II

Please answer the following questions regarding your child's health history.

Number of times diagnosed with a concussion (excluding current injury):

Concussions that resulted in loss of consciousness:

Concussions that resulted in confusion:

Concussions that resulted in difficulty remembering events that occurred immediately after injury:

Concussions that resulted in difficulty remembering events that occurred:

Total games missed as a result of all concussions combined:

Concussion history (please list approx dates):

Treatment for Headaches by Physician:

Treatment for Migraine Headaches by Physician:

Treatment for Epilepsy/Seizures:

History of Brain Surgery:

History of Meningitis:

Treatment for Substance/Alcohol Abuse:

Treatment for Psychiatric Condition (Depression, Anxiety):

Diagnosed with ADD/ADHD:

Diagnosed with Dyslexia:

Number of Hours Sleep Last Night:

Diagnosed with Autism:

Strenuous Exercise in the Last 3 Hours:

Current Medications:

Section III

Please complete the following section together with your child. On a scale of 0 to 6 (0 being the least and 6 being the most) please rate the following symptoms your child is currently experiencing. Please keep in mid this is referring to symptoms your child is experiencing at the present time, and not referring to symptoms experienced with past injuries.

Headache:

Nausea:

Sensitivity to Noise:

Irritability:

Vomiting:	Sadness:
Balance Problems:	Nervousness:
Dizziness:	Feeling More Emotional:
Fatigue:	Numbness or Tingling:
Trouble Falling Asleep:	Feeling Slowed Down:
Sleeping More Than Usual:	Feeling Mentally Foggy:
Sleeping Less Than Usual:	Difficulty Concentrating:
Drowsiness:	Difficulty Remembering:
Sensitivity to Light:	Visual Problems: