Mt. Diablo Memory Center Sport Concussion Program

Name of Student: _____ Date: _____

Address: _____

Phone: _____ Email (required): _____

I, _____, parent of the above-named student, acknowledge having read and understood the Informed Consent for Treatment, Explanation of Services and Care Protocol as provided to me by Dr. Eric Freitag. If there is a custody/guardian or other legal arrangement that requires more than one signature for this minor child to receive treatment, I accept all responsibility for obtaining all necessary signatures below.

_____ _____

Signature of Parent/Guardian of Minor Date Signature of Second Legal Guardian Date

_____

Signature of Patient (if age 14 or over)

Date of Birth: _____ Height: _____ft _____in Weight: _____ lbs Gender: M F

Handedness: Left Right Ambidextrous Native Country/Region: _____

Native Language: _____ Second language (if fluent in speaking/writing): _____

Years of education completed excluding kindergarten (e.g. high school senior = 11 years): _____

What type of student were/are you? □ Below Average □ Average □ Above Average

Check all that apply:

□ Received speech therapy □ Attended special education classes □ Repeated one or more years of school

□ Diagnosed ADD/ADHD □ Diagnosed learning disability □ Diagnosed dyslexia □ Diagnosed autism

Current Sport: _____ Position/event/class: _____

Level of participation (e.g. club, junior high): _____ Years at this level: _____

Have you ever had:
- □ Treatment by physician for headaches
- □ Treatment by physician for migraines
- □ Treatment for epilepsy/seizures
- □ Treatment for brain surgery
- □ Treatment for meningitis
- □ Treatment for substance/alcohol abuse
- □ Treatment for psychiatric condition (i.e. depression/anxiety)

_____ Number of diagnosed concussions

_____ Number of concussions resulting in confusion

_____ Number resulting in difficulty remembering events that occurred just after injury

_____ Number resulting in difficulty remembering events that occurred just before injury

_____ Total number of games ever missed due to concussion

Number of hours of sleep last night: _____ Date of last concussion: _____

Have you participated in strenuous exercise/exertion in the last three hours? YES NO

PLEASE LIST LAST FIVE CONCUSSIONS AND ANY PRESCRIPTION MEDICATIONS ON THE BACK OF THIS SHEET.