ImPACT Testing Demographics Sheet

The following questions are asked at the beginning of the ImPACT test. Please PRINT clearly to ensure accuracy. Please fill this form out with a parent/guardian to insure the most accurate information. Upon completion of the ImPACT test, this form will be included in the child's individual records kept in the athletic training room.

Date of Birth (mm/dd/yyyy) _____

Name: First: _____ Last: _____

Height (ft and in): _____ Weight (in lbs): _____

Gender: _____ Handedness (Right, Left, Both): _____

Native Country: _____ Email: _____

Native Language: _____ Second Language: _____

Total Years of Education (not including Kindergarten): _____
(Example: Freshman 8; Sophomore 9; Junior 10; Senior 11)

Please Check all That Apply:

_____ Received Speech Therapy _____ Attended (s) Special Education Classes

_____ Repeated a Grade _____ Diagnosed with a Learning Disability

_____ Diagnosed Attention Deficit and/or Hyperactive (ADD/ADHD)

Please Check One: While in school what type of student are/were you:

_____ Below Average _____ Average _____ Above Average

Sport are you currently playing_____ Position/Event/Class _____

Please Check the level that you are currently competing in:

_____ Profession _____ Semi-Professional _____ Collegiate _____ High School

_____ Junior High School/Middle School _____ Other

How many years you have played at this level? (do not count this current year): _____

Please turn over; more questions on the back.

For the following questions about your injury history, please place your answers on the lines provided:

_____ The number of times you have been diagnosed with a concussion

_____ The total number of concussions that resulted in the loss of consciousness

_____ The total number of concussions that resulted in confusion

_____ The total number of concussions that resulted in difficulty with memory for events occurring immediately after the injury

_____ The total number of concussions that resulted in difficulty with memory for events occurring immediately before the injury

_____ Total number of games missed as a direct result of all concussions combined

Please list the five most recent concussions you have sustained by date (you can approximate):

1. _____
2. _____
3. _____
4. _____
5. _____

For the next set of questions please circle yes or no for each of the statements as they relate to you:

YES or NO Treatment received for headaches by a physician

YES or NO Treatment for migraine headaches by a physician

YES or NO Treatment for epilepsy/seizures

YES or NO Treatment for brain surgery

YES or NO Treatment for meningitis

YES or NO Treatment for substances/alcohol

YES or NO Treatment for psychiatric conditions such as depression or anxiety

If you have questions, need follow up care or more information, please contact
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