Robert M. Cain, MD
5508 Parkcrest Drive, Suite 310, Austin, Texas 78731

Patient Name:_____Date of Birth:_____Today's Date:_____

Concussion Questionnaire

	LEAVE BLANK FOR DOCTOR'S USE
1. Did you have a Concussion? When?	
2. Did patient lose consciousness? If so, for how long?	
3. What was the patient's last memory or last recall BEFORE the injury? What was the patient's first memory or recall AFTER the injury?	
4. Was there associated nausea? Or nausea and vomiting?	
5. Was there associated memory disturbance? Describe.	
6. Was there associated dizziness? Describe. If so, describe the dizziness and when it started:	
7. Was there any associated headache? If so, please describe the headache and when it started:	
8. Was there any associated balance disturbance? If so, describe:	
9. Was there any associated sleep disturbance? If so, please describe and when it started:	

Patient Name:_____

Concussion Questionnaire (con't)

	LEAVE BLANK FOR DOCTOR'S USE
10. Was there any disturbance of dreams? If so, please describe:	
11. Was there any change in work performance or school performance?	

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS

If so, please describe:	
12. Is there a prior history of previous concussions with or without loss of consciousness? If so, please describe:	
13. Was there any hearing loss or ringing in the ears? If so, please describe:	
14. Was there any associated depression or anxiety related to the injury? If so, please describe:	
15. Did you have depression or anxiety before the injury?	
16. Was there any change in mood or increased irritability? If so, please describe:	
17. Are your symptoms gradually getting better, the same, or worse? Please describe:	

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS