Concussion Patient Case Presentation Form

PLEASE FILL OUT THIS FORM ON YOUR COMPUTER

Please do not include any patient identifying data.
This case form is the only document used for your ECHO case.
Do not send any supplementary materials or share documents from your screen during the case presentation.

Presenter: Site: Date:

How long have you been seeing the patient?

How many visits have you had with the patient?

Brief Patient Demographics

Age Sex

Occupation

Employed: FT ☐ PT ☐ Unemployed ☐ Employed prior to Concussion? Yes ☐ No ☐

Current Student? Yes ☐ No ☐ If you answered yes: FT ☐ PT ☐

Living arrangement and circumstances (lives alone, with significant other/family, stability of housing)

Concussion details

Date of presenting injury

Details of presenting injury
(description of event, including cause and circumstances of injury)

Details

Injury Severity

Other/unknown (explain)

Loss of Consciousness If yes, duration

Witnessed Yes ☐ No ☐

Post-Traumatic Amnesia If yes, duration

Glasgow Coma Scale

ER visit: Yes ☐ No ☐

Number of prior concussions:

Relevant details of prior concussions

Details

Neuroimaging:

CT completed: Yes ☐ No ☐

MRI completed: Yes ☐ No ☐

Additional Comments:

Current Symptom Profile

Primary **current** complaints

	No complaint	Minor complaint	Moderate complaint *(interfering but not stopping daily activity)*	Severe complaint *(unable to complete daily activities)*	Don't know
Light sensitivity					
Sound sensitivity					
Headache					
Dizziness					
Attention/concentration problems					
Reduced processing speed					
Memory problems					
"Fogginess"					
Balance problems					
Depression symptoms					
Anxiety symptoms					
Increased irritability					
Sleep changes					

Comments on symptom profile

Treatments/consultations:

Brief history of treatments/consultations for concussion (include referrals to neurologists, psychologists, chiropractors, OTs, PTs, etc.) (indicate if in past or current)

Details

Medication Use:

Current medication use (name of any medication and dose; please specify if related to concussion)

Medical history

Past psychiatric history:

Does patient have a past history of any psychiatric diagnoses (e.g., mood disorder, anxiety disorder)? Yes ☐ No ☐

Description (If yes)

Substance use

Currently using:

☐ Alcohol ☐ Nicotine ☐ Cannabinoids

☐ Non-prescription drugs (list all):

☐ Other

Substance abuse history? ☐ Yes ☐ No

If yes, describe history

Neurological history (select all that apply):

Stroke	Yes ☐	No ☐	Meningitis	Yes ☐	No ☐
TIA	Yes ☐	No ☐	Encephalitis	Yes ☐	No ☐
TBI	Yes ☐	No ☐	Headache	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐			

Other neurological

Other medical Conditions (select all that apply)

☐ Cancer	☐ Circulatory disease	☐ Diabetes	☐ Digestive
☐ Epilepsy	☐ Heart Disease	☐ Hematological	☐ Hypertension
☐ Kidney disease	☐ Respiratory	☐ Sleep Apnea	☐ Thyroid Disease

Other:

What would you like help with regarding this concussion patient?

***IMPORTANT* PLEASE SAVE THIS DOCUMENT AS A PDF BEFORE CLOSING TO AVOID LOSING INFORMATION**

ECHO Staff Use:

SIGNATURE:

DATE:

SIGNATURE:

DATE: