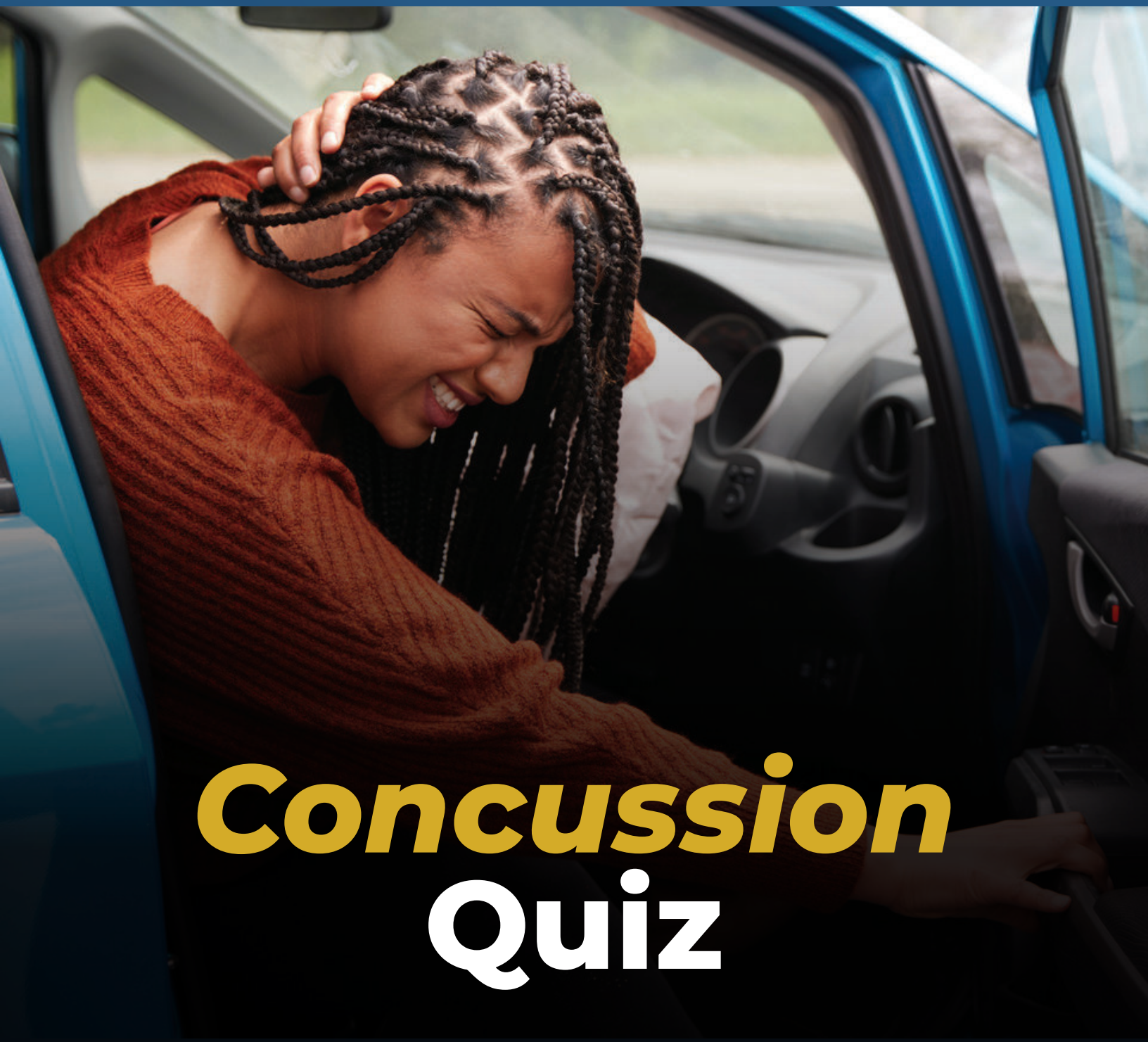
C&S CORDISCO & SAILE LLC



Concussion Quiz

CONTACT US

info@cordiscosaile.com

215-642-2335

If you believe you have a concussion:

		YES	NO
1	Have you recently experienced an impact to the head or a sudden force or movement that strained your neck and spine (whiplash)?	○	○
2	Did you lose consciousness, even temporarily?	○	○
3	Are you experiencing disorientation, confusion, trouble concentrating, and/or remembering things?	○	○
4	Are you experiencing blurred, double vision, or loss of part of the field of vision?	○	○
5	Did you lose, at any point, the ability to move any part of your body?	○	○
6	Are you dizzy, nauseated, or vomiting?	○	○
7	Are you experiencing new headaches or a sensation of pressure in your head?	○	○
8	Are you feeling lightheaded or having trouble balancing?	○	○
9	Are you sensitive to light or noise?	○	○
10	Are you experiencing a loss of sense of smell?	○	○
11	Do you have ringing in your ears?	○	○

		YES	NO
12	Are you feeling sluggish, foggy, or drowsy?	○	○
13	Are you sleeping more — or less — after an injury or accident?	○	○
14	Have you experienced any mood changes? (depressed, sad, irritable and/or anxious?	○	○

Self Scoring:

Question **#1** is mandatory "**YES**". If you answer "**NO**", you probably do not have concussion.

- If you answered at least one "**YES**" to question **#1** through **#6**, you probably have a concussion.

- If you answered "**YES**" at least 3 of questions from **#7** to **#14**, you probably have a concussion.

If you are with someone who has sustained a head injury:

		YES	NO
1	Do they know their name, where they are, what day it is, and what just happened?	○	○
2	Are they experiencing weakness, numbness, or tingling anywhere?	○	○
3	Is their speech slurred?	○	○
4	Are they restless, agitated, or confused—or exhibiting other mood or behavior changes?	○	○
5	Are their movements clumsy?	○	○
6	Are their pupils the same size? Is one larger than the other?	○	○
7	Can they follow your finger motion with both eyes?	○	○
8	Are they answering questions slowly?	○	○
9	Can they recall events before or after a blow to the head?	○	○
10	Can they follow instructions?	○	○

- If they answered at least one "**YES**" to question **#1** through **#5**, they probably have a concussion.
- If they answered at least 3 "**YES**" of questions **#6** to **#10**, they probably have a concussion.

CLIENT SYMPTOMOLOGY-BASED QUESTIONNAIRE

If you seek legal help from Cordisco & Saile after a traumatic brain injury, our attorneys may walk through the following questionnaire to understand the full extent of your injuries and help advocate for your brain injury case.

Please Note:

This questionnaire is designed to be used by non-clinical professionals to determine if a client exhibits or expresses the signs and symptoms of a Post Concussive Injury or Traumatic Brain Injury without clear clinical evidence of a TBI such as positive scans or surgical intervention. This form should be implemented following the 90th day post injury to allow time for spontaneous recovery.

This Evaluation is to be performed by a Paralegal or Attorney in the presence of the injured individual and with a family member or friend who knew the client before and after the injury present to substantiate responses. Injured individuals are often in denial about their own deficits.

Disclaimer:

This form is not intended to be a clinical/medical evaluation unless administered by a licensed healthcare provider. All other use is educational in nature and should only be used to indicate need for further evaluation by appropriate healthcare professionals.

Individual's Name:	DOB:
Current Address:	
Contact Phone:	Date of Ijury:
Cause of Injury Describe or Circle one: MVC Fall Stroke Aneurysm Assault Sports Injury Toxic Exposure	
Other Describe:	Work Related? ◯ YES ◯ NO

PREVIOUS INJURY OR EXPOSURE INFORMATION

Prior to the Current Injury were there any

Impact injuries to the Head or Brain?

1. _____

- ◯ with head impact
- ◯ without head impact
- ◯ Amnesia/disorientation
- ◯ loss of consciousness
- ◯ post-injury confusion or headaches
- ◯ concussion

2. _____

- ◯ with head impact
- ◯ without head impact
- ◯ Amnesia/disorientation
- ◯ loss of consciousness
- ◯ post-injury confusion or headaches
- ◯ concussion

3. _____

- ◯ with head impact
- ◯ without head impact
- ◯ Amnesia/disorientation
- ◯ loss of consciousness
- ◯ post-injury confusion or headaches
- ◯ concussion

Motor vehicle accidents:

Anoxia (a sustained lack of oxygen):

Exposure to toxins:

Severe viral infection or illness:

Other:

PREVIOUS SCANS	◯ YES ◯ NO
MRI Results:	Year:
CT Results:	Year:
EEG Results:	Year:
Neuropsychological Testing Results:	Year:

Developmental Information Applicable	◯ N/A
Adoptee:	◯ YES ◯ NO
Was there any birth trauma (vacuum, forceps, cord wrapped, toxic exposure?	
MVC during pregnancy?	◯ YES ◯ NO
If yes, please describe all that apply:	
Type of birth ◯ Vaginal ◯ C-Section	Duration of birth/labor in hours:
List any recurrent or severe childhood illness:	
Were there any delays in language or development?	◯ YES ◯ NO
If Yes, please explain:	
Did the person attend any special education (ESE) classes in school?	◯ YES ◯ NO
If Yes, what classes and what year(s) of school?	

PREVIOUS TRAUMA OR ABUSE HISTORY

Please check all that apply:

- ◯ NONE
- ◯ Emotional Abuse
- ◯ Physical Abuse
- ◯ Sexual Abuse
- ◯ Other Major Trauma

Other Please Describe:

SIGNIFICANT FAMILY HISTORY OF MAJOR MEDICAL, PSYCHIATRIC OR NEURODEGENRATIVE DISEASES

- ◯ Dementia
- ◯ Alzheimer's
- ◯ Mental Illness
- ◯ Bipolar Disorder
- ◯ Schizophrenia
- ◯ Anxiety Disorders
- ◯ Obsessive Compulsive Disorder
- ◯ Other: _____

- ◯ Strokes
- ◯ Aneurysm
- ◯ Diabetes
- ◯ Cancer
- ◯ Heart Disease
- ◯ Other: _____

Pre-Injury Psychiatric Diagnosis (Specify):

Treatment:

SLEEP

Did you have sleep issues before the injury? ◯ YES ◯ NO

SLEEP DISTURBANCES

Are any of the following different after the injury?	
Difficulty Falling Asleep?	◯ YES ◯ NO
Average Hours of Sleep per night	
Difficulty Staying Asleep?	◯ YES ◯ NO

Restless Legs?	◯ YES ◯ NO
Frequent Nighttime Urination?	◯ YES ◯ NO
Do You Currently Use a Sleeping Pill?	◯ YES ◯ NO
Did You Use a Sleeping Pill Prior to the Injury?	◯ YES ◯ NO
Have You Participated in A Sleep Study?	◯ YES ◯ NO
If So Date and Facility:	
Have You Been Diagnosed with Sleep Apnea?	◯ YES ◯ NO
Do You Have Nightmares?	◯ YES ◯ NO
Do You Take Naps?	◯ YES ◯ NO

Length of Daily Naps

Do You Have Difficulties Staying Awake?	◯ YES ◯ NO
Do You Feel Rested and Refreshed Upon Awakening?	◯ YES ◯ NO
Do You Feel More Rested If You Sleep Longer?	◯ YES ◯ NO
Comments:	

HEADACHES

Did you suffer from Chronic Headaches or Migraines prior to your injury? ◯ YES ◯ NO

If Yes, for how long were you treated?

Describe history and treatment?

Do you suffer from Chronic Headaches or Migraines after your injury? ◯ YES ◯ NO

What Was the Date of Your Last Headache?

How long do they typically last?

Please Describe Physical Symptoms That Occur (Throbbing, Pressure, what part of the head do they start in? Please Specify in Detail):

On A Pain Scale of 1-10 With 10 Being the Worst, please rate your headaches?

DO ANY OF THE FOLLOWING TRIGGER A HEADACHE?

Reading for More Than 15 Minutes? ◯ YES ◯ NO

Using Electronic Equipment for More Than 15 Minutes including;

Computer, Tablet, Cell phone Television? ◯ YES ◯ NO

Noise? ◯ YES ◯ NO Lights? ◯ YES ◯ NO

DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS DURING A HEADACHE?

Nausea? ◯ YES ◯ NO	Light Sensitivity? ◯ YES ◯ NO
Sound Sensitivity? ◯ YES ◯ NO	Dizziness? ◯ YES ◯ NO

Do You Use Over the Counter Products? ◯ YES ◯ NO

If So, Which Ones, How much and how often?

Are they effective? ◯ YES ◯ NO

BALANCE

Balance: Different Post Injury ◯ YES ◯ NO

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

Dizziness?	◯ YES ◯ NO	Lightheadedness?	◯ YES ◯ NO
Falling Due to Imbalance?	◯ YES ◯ NO		
Do you have to use handrails on stairs now when you didn't before?	◯ YES ◯ NO		
Feel More Stable When Pushing a Cart in the Grocery Store?	◯ YES ◯ NO		
Do You Hit Your Sides When Walking Through Doorways?	◯ YES ◯ NO		
Comments:			

MEMORY

DO YOU EXPERIENCE THE FOLLOWING?

Misplacing Items as You Use Them?	◯ YES ◯ NO
Misplace Items You Use Daily?	◯ YES ◯ NO
Feel More Forgetful?	◯ YES ◯ NO
Have Difficulty Remembering to Pay the Bills?	◯ YES ◯ NO
Have Difficulty Remembering Important Events (I.E. Birthdays, Etc.)?	◯ YES ◯ NO
Forget to Keep Scheduled Appointments?	◯ YES ◯ NO
Forget Tasks Assigned to You?	◯ YES ◯ NO
Feel Panicked If You Do Not Recognize Your Surroundings?	◯ YES ◯ NO
Experience Times When You Cannot Recall Your Actions?	◯ YES ◯ NO
More Dependent on Reminders or Memory Strategies like Cell Phone?	◯ YES ◯ NO

PLANNING/ ORGANIZING/ EXECUTIVE FUNCTIONING

DO YOU HAVE DIFFICULTY WITH THE FOLLOWING?

Being on Time for Appointments?	◯ YES	◯ NO
Walking into a Room and Forgetting What You Were Doing?	◯ YES	◯ NO
Creating a Plan B If Your Original Plan Does Not Work?	◯ YES	◯ NO
Budget Money to Cover Expenses?	◯ YES	◯ NO
Making Decisions Without Considering All Factors?	◯ YES	◯ NO
Being in Touch/Recognizing the Needs of Others?	◯ YES	◯ NO
Getting "Stuck" Doing a Task When another Task Is More Important?	◯ YES	◯ NO
Unmotivated and Lack Initiation?	◯ YES	◯ NO

EMOTIONAL LABILITY: MOOD/DEPRESSION

Do You Feel Like you can have fun?	◯ YES	◯ NO
Do You Frequently Experience Crying Episodes?	◯ YES	◯ NO
Crying That Is Triggered by Stress?	◯ YES	◯ NO
If So, Do You Feel Relief After?	◯ YES	◯ NO
Have You Experienced Changes in Appetite?	◯ YES	◯ NO
If Yes, Please Explain:		
Have You Experienced Changed in Weight?	◯ YES	◯ NO
If So, How Much and How Often?		
Do You Feel Optimistic About the Future?	◯ YES	◯ NO
Has There Been Any Changes in Libido?	◯ YES	◯ NO
If Yes, Please Explain:		
Do you feel your mood is no different than usual?	◯ YES	◯ NO

EMOTIONAL LABILITY: ANXIETY

Did You Have Symptoms of or Received Treatment for Anxiety Prior to your Injury?	◯ YES ◯ NO
If Yes diagnosis and medications	
Do You Currently Experience Periods of Anxiety?	◯ YES ◯ NO
If Yes, what treatment and or meds?	

DO YOU FEEL ANXIOUS DURING THE FOLLOWING?

If You Do Not Recognize Your Surroundings?	◯ YES ◯ NO
When There Is Sudden Movement Around You?	◯ YES ◯ NO
With Loud or Sudden Noises?	◯ YES ◯ NO
In Crowds?	◯ YES ◯ NO
While in Stores or Other Familiar Community Areas?	◯ YES ◯ NO
With Unfamiliar People?	◯ YES ◯ NO
While Driving?	◯ YES ◯ NO
With Unfamiliar People?	◯ YES ◯ NO
Do you worry about making the right decision?	◯ YES ◯ NO
Do you often feel restless?	◯ YES ◯ NO
Do you worry something bad is going to happen anytime?	◯ YES ◯ NO
Do you get nervous when things don't go as planned?	◯ YES ◯ NO
Do you often worry or obsess about things that don't really matter?	◯ YES ◯ NO
Are you obsessed that harmful stuff might happen in the future?	◯ YES ◯ NO
Do You obsess about death?	◯ YES ◯ NO
Do you find it hard to shut off your mind at bedtime because you are worrying?	◯ YES ◯ NO
Does the thought of getting out of bed to face the day stress you out?	◯ YES ◯ NO

EMOTIONAL LABILITY: ANXIETY

Did You Have Symptoms of or Received Treatment for Anxiety Prior to your Injury?	◯ YES ◯ NO
If Yes diagnosis and medications	
Do You Currently Experience Periods of Anxiety?	◯ YES ◯ NO
If Yes, what treatment and or meds?	

DO YOU FEEL ANXIOUS DURING THE FOLLOWING?

If You Do Not Recognize Your Surroundings?	◯ YES ◯ NO
When There Is Sudden Movement Around You?	◯ YES ◯ NO
With Loud or Sudden Noises?	◯ YES ◯ NO
In Crowds?	◯ YES ◯ NO
While in Stores or Other Familiar Community Areas?	◯ YES ◯ NO
With Unfamiliar People?	◯ YES ◯ NO
While Driving?	◯ YES ◯ NO
With Unfamiliar People?	◯ YES ◯ NO
Do you worry about making the right decision?	◯ YES ◯ NO
Do you often feel restless?	◯ YES ◯ NO
Do you worry something bad is going to happen anytime?	◯ YES ◯ NO
Do you get nervous when things don't go as planned?	◯ YES ◯ NO
Do you often worry or obsess about things that don't really matter?	◯ YES ◯ NO
Are you obsessed that harmful stuff might happen in the future?	◯ YES ◯ NO
Do You obsess about death?	◯ YES ◯ NO
Do you find it hard to shut off your mind at bedtime because you are worrying?	◯ YES ◯ NO
Does the thought of getting out of bed to face the day stress you out?	◯ YES ◯ NO

VETERAN HISTORY

Have you ever serve in the Armed Forces? ◯ YES ◯ NO

◯ Are you Active ◯ Retired

◯ Medically Discharged ◯ Honorable Discharge

◯ Reserves/National Guard

Have you ever been deployed to a war zone? ◯ YES ◯ NO

If Yes When and Where?

Have You Ever Been in Combat? ◯ YES ◯ NO

How many Combat Deployments?

Were you ever involved in an IED/Roadside bomb or other explosion? ◯ YES ◯ NO

If Yes were you ever diagnosed with a Concussion to Traumatic Brain Injury? ◯ YES ◯ NO

Have you ever been diagnosed with PTSD? ◯ YES ◯ NO

If Yes, please explain:

FAST SYMPTOM CHECKLIST

- ◯ Anger management problems
- ◯ Balance problems
- ◯ Blurred/double vision
- ◯ Cognitive decline or changes
- ◯ Cognitive function problems
- ◯ Compulsive behavior
- ◯ Confusion
- ◯ Decreased judgment
- ◯ Delusions
- ◯ Difficulty following instructions
- ◯ Disorganization
- ◯ Disorientation
- ◯ Difficulty integrating information
- ◯ Distractibility
- ◯ Fainting spells
- ◯ Difficulty with concentration
- ◯ Excessive sadness
- ◯ Fatigue
- ◯ Difficulty learning new things
- ◯ Flashbacks of trauma
- ◯ Frequent dizziness
- ◯ Frequent headaches
- ◯ General anxiety
- ◯ Greif for loss of self
- ◯ Hallucinations
- ◯ Hot flashes
- ◯ Impulsivity
- ◯ Inappropriate guilt
- ◯ Increased appetite
- ◯ Increased energy
- ◯ Insomnia
- ◯ Involuntary tics/tremors
- ◯ Irritability
- ◯ Long-term memory problems
- ◯ Losing things
- ◯ Loss of appetite
- ◯ Loss of interest in things
- ◯ Loss of motivation
- ◯ Mood swings
- ◯ Low frustration tolerance
- ◯ Racing thoughts
- ◯ Panic attacks
- ◯ Making careless mistakes
- ◯ Muscle pain
- ◯ Paranoia
- ◯ Muscle spasms
- ◯ Nausea
- ◯ Performance anxiety
- ◯ Nightmares
- ◯ Obsessive thoughts
- ◯ Personality changes
- ◯ Problems paying attention
- ◯ Promiscuity
- ◯ Risky behavior
- ◯ Problems with word finding
- ◯ Psychotic episodes
- ◯ Ringing in ears
- ◯ Restlessness/Fidgetiness
- ◯ Sensitivity to sound
- ◯ Sensitivity to touch
- ◯ Self-mutilation (cutting)
- ◯ Sleeping too much
- ◯ Social anxiety
- ◯ Sensitivity to light
- ◯ Suicidal thoughts
- ◯ Suicide plans
- ◯ Suicide attempt(s)
- ◯ Talkativeness
- ◯ Worry
- ◯ Short-term memory problems

FAST DIAGNOSIS CHECKLIST

- ○ ADD/ADHD
- ○ Alcoholism
- ○ Alzheimer's
- ○ Anxiety
- ○ Arthritis
- ○ Asperger's
- ○ Autism
- ○ Autoimmune disorder
- ○ Back injuries
- ○ Bipolar spectrum disorder
- ○ Birth deformities
- ○ Bleeding problems
- ○ Blood transfusions
- ○ Brain injury
- ○ Brain tumor
- ○ Borderline personality disorder
- ○ Cancer
- ○ Cerebral palsy
- ○ High Cholesterol
- ○ Dementia
- ○ Depression
- ○ Diabetes
- ○ Eating disorder
- ○ Fatigue
- ○ Fibromyalgia
- ○ Headaches (migraine)
- ○ Headaches (tension)
- ○ Hearing problems
- ○ Hypertension
- ○ HIV
- ○ Kidney disease
- ○ Liver disease
- ○ Lupus
- ○ Lyme disease
- ○ Menopause
- ○ Multiple sclerosis
- ○ Neck or Spine injury
- ○ Panic attacks
- ○ Parkinson's disease
- ○ Obsessive compulsive disorder
- ○ PTSD
- ○ Schizophrenia
- ○ Sleep apnea
- ○ Stomach ulcers
- ○ Stroke
- ○ Substance abuse
- ○ Thyroid problems
- ○ Seizure disorder
- ○ Oppositional defiant disorder
- ○ Sexually transmitted disease

When submitting the questionnaire for review please submit any of the following imaging or testing reports and all medical records available.

PLEASE PROVIDE ANY OF THE FOLLOWING TESTS THAT HAVE BEEN DONE.

Requested Imaging or Testing

- **CT-MRI-Fmri-PET-SPECT-DTI**
- **EEG or QEEG**
- **Sleep Study**
- **Swallow Study**
- **Vestibular Testing**
- **PT OT and SLP Notes for any treatment**
- **List of Current Treating Physicians**
- **Neuropsychology, Psychiatry, and Neurology reports.**

Blood Work or Labs			
Liver Panel	Prolactin	Lipid Profile	Hepatitis Profile
CBC, CMP	Insulin Growth Factor	Free Total Testosterone male patients only)	Anti-DNA screen if POS for ANA
UA	Folate	HGB	LH
TSH, T-4 Free	C Reactive Protein	A1C	Ferritin Levels
FSH	Ammonia	Vitamin B-12 Levels	Vitamin D3

****Any Current Psychotropic Therapeutic Drug Level. Any Drug Levels that Require Therapeutic Levels***

Concussion Quiz

CORDISCO & SAILE LLC

Get In Touch

Email: **info@cordiscosaile.com**

Phone: **215-642-2335**

cordiscosaile

cordiscosaile

cordiscosaile

@cordiscosaile

@CordiscoSaileLLC

https://www.cordiscosaile.com/