

**Traumatic Brain Injury (TBI) Documentation**

**Name of student:** \_\_\_\_\_

**Date of injury:** \_\_\_\_\_

*In order to help this student adapt to college life after his/her injury, please supply (in as much detail as possible) answers to the questions that follow. Feel free to attach any reports to the back of this form.*

**Please complete all items about which you have a history or have assessed in the course of clinical evaluation. If you wish to, please attach any relevant reports to the back of this form.**

**I. History of concussions**

\_\_\_ Number of concussions with loss of consciousness      Date(s) \_\_\_\_\_

\_\_\_ Number of concussions without loss of consciousness      Date(s) \_\_\_\_\_

Hospitalization with any of these injuries? \_\_\_ Yes \_\_\_ No

Surgery needed for any of these injuries? \_\_\_ Yes \_\_\_ No

If the answer to the either question above is “yes,” please provide details here:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**II. Post-concussive status**

Signs and symptoms	Check if present now
fatigue	
attentional problems	
balance problems	
dizziness	
noise sensitivity	
light sensitivity	
headaches	
sleep problems	
memory problems	

Signs and symptoms	Check if present now
amnesia (outside of the concussion event)	
confused periods	
seizures	
personality change	
irritability	
behavioral problems	
anxiety	
depression	

**III. Check if there is any prior history of:**

- |   |   |
|---|---|
| <input type="checkbox"/> special education          | <input type="checkbox"/> meningitis/encephalitis              |
| <input type="checkbox"/> learning disability        | <input type="checkbox"/> substance/alcohol abuse              |
| <input type="checkbox"/> attention deficit disorder | <input type="checkbox"/> psychiatric/psychological counseling |

**IV. Please provide reports from any neuropsychological/educational testing related to TBI or any items in section III above. Attach at the back of this form.**

**V. List any current medications and dosage, and the name of the prescribing M.D.**

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**VI. Please comment on the particular problems that may impair this student's functioning in the post-secondary school environment (e.g. The student/patient has difficulty functioning in the morning).**

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Name of doctor completing this form (please print): \_\_\_\_\_

Signature of doctor completing this form: \_\_\_\_\_

Date: \_\_\_\_\_