



# **Concussion** **Quiz**

CONTACT US

✉ [info@cordiscosaille.com](mailto:info@cordiscosaille.com)

☎ 215-642-2335

<https://www.cordiscosaille.com/>

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)?	<input type="radio"/>	<input type="radio"/>
2 Did you lose consciousness, even temporarily?	<input type="radio"/>	<input type="radio"/>
3 Are you experiencing disorientation, confusion, trouble concentrating, and/or remembering things?	<input type="radio"/>	<input type="radio"/>
4 Are you experiencing blurred, double vision, or loss of part of the field of vision?	<input type="radio"/>	<input type="radio"/>
5 Did you lose, at any point, the ability to move any part of your body?	<input type="radio"/>	<input type="radio"/>
6 Are you dizzy, nauseated, or vomiting?	<input type="radio"/>	<input type="radio"/>
7 Are you experiencing new headaches or a sensation of pressure in your head?	<input type="radio"/>	<input type="radio"/>
8 Are you feeling lightheaded or having trouble balancing?	<input type="radio"/>	<input type="radio"/>
9 Are you sensitive to light or noise?	<input type="radio"/>	<input type="radio"/>
10 Are you experiencing a loss of sense of smell?	<input type="radio"/>	<input type="radio"/>
11 Do you have ringing in your ears?	<input type="radio"/>	<input type="radio"/>

	YES	NO
12 Are you feeling sluggish, foggy, or drowsy?	<input type="radio"/>	<input type="radio"/>
13 Are you sleeping more — or less — after an injury or accident?	<input type="radio"/>	<input type="radio"/>
14 Have you experienced any mood changes? (depressed, sad, irritable and/or anxious?)	<input type="radio"/>	<input type="radio"/>

### 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.

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- 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?	<input type="radio"/>	<input type="radio"/>
2 Are they experiencing weakness, numbness, or tingling anywhere?	<input type="radio"/>	<input type="radio"/>
3 Is their speech slurred?	<input type="radio"/>	<input type="radio"/>
4 Are they restless, agitated, or confused—or exhibiting other mood or behavior changes?	<input type="radio"/>	<input type="radio"/>
5 Are their movements clumsy?	<input type="radio"/>	<input type="radio"/>
6 Are their pupils the same size? Is one larger than the other?	<input type="radio"/>	<input type="radio"/>
7 Can they follow your finger motion with both eyes?	<input type="radio"/>	<input type="radio"/>
8 Are they answering questions slowly?	<input type="radio"/>	<input type="radio"/>
9 Can they recall events before or after a blow to the head?	<input type="radio"/>	<input type="radio"/>
10 Can they follow instructions?	<input type="radio"/>	<input type="radio"/>



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 Injury:
Cause of Injury Describe or Circle one: MVC    Fall    Stroke    Aneurysm    Assault    Sports Injury    Toxic Exposure	
Other Describe:	Work Related? <input type="radio"/> YES <input type="radio"/> 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

loss of consciousness

without head impact

post-injury confusion or headaches

Amnesia/disorientation

concussion

2. \_\_\_\_\_

with head impact

loss of consciousness

without head impact

post-injury confusion or headaches

Amnesia/disorientation

concussion

3. \_\_\_\_\_

with head impact

loss of consciousness

without head impact

post-injury confusion or headaches

Amnesia/disorientation

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 NEURODEGENERATIVE 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

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YES  NO

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YES  NO

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YES  NO

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YES  NO

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YES  NO

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YES  NO

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

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

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## Get In Touch

Email: [info@cordiscoaile.com](mailto:info@cordiscoaile.com)

Phone: **215-642-2335**



cordiscoaile



cordiscoaile



cordiscoaile



@cordiscoaile



@CordiscoSaileLLC

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• <https://www.cordiscoaile.com/> •

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