Head Injury Tracker (HIT) Evaluation

INJURY INFORMATION: H.I.T. ID:_____

Injury Date: _____ Injury Time:_____

Birth Year: _____ Gender: _____ Male _____ Female

Handedness: _____ Left _____ Right _____ Ambidextrous

Patient Type: _____ Athlete (Please answer 1-4) _____ Non-athlete (Please answer 3 & 4 only)

1. Primary sport at time of concussion: _____
2. Was the subject in season at time of injury?: _____ Yes _____ No
3. Has the concussion occurred during a team related activity?: _____ Yes _____ No
4. What activity was the subject performing when the concussion occurred?
   _____ Practice _____ Game _____ Other sporting activity* _____ Non-sporting activity*
   *(If selected other or non-sporting activity, please specify): _____

MEDICAL HISTORY:
Does the patient have a learning disability, dyslexia, ADD/ADHD? _____ Yes * _____ No
*If yes, is the person currently taking any medication for learning disability, dyslexia, ADD/ADHD?

Has the patient ever been diagnosed with headache or migraines? _____ Yes* _____ No
*If yes, is the person currently taking any medication for headache or migraines?

Has the patient ever been diagnosed with depression, anxiety or other psychiatric disorder? __Yes*
__No
*If yes, is the person currently taking any medication for depression, anxiety or other psychiatric disorder?

Has the patient had a concussion prior to the current injury? _____ Yes* _____ No
*If yes, how many prior concussions has the patient suffered prior to the current injury?: _____

RETURN DATES:
Are the academic return dates available? _____ Not Yet _____ Yes* _____ Unavailable*
*If yes, what is the date? _____
*If unavailable, _____ Withdrew from school _____ No follow-up available

Are the athletic return dates available? _____ Not Yet _____ Yes* _____ Unavailable*
*If yes, what is the date? _____
*If unavailable, _____ Withdrew from school _____ No follow-up available

Please complete attached symptom checklist

Evaluator: _____

Date Evaluation Completed: _____

Symptom Checklist

Headache	0	1	2	3	4	5	6
“Pressure in Head”	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or Vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred Vision	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Sensitivity to Light	0	1	2	3	4	5	6
Sensitivity to Noise	0	1	2	3	4	5	6
Feeling Slowed Down	0	1	2	3	4	5	6
Feeling Like “In a Fog”	0	1	2	3	4	5	6
“Don’t Feel Right”	0	1	2	3	4	5	6
Difficulty Concentrating	0	1	2	3	4	5	6
Difficulty Remembering	0	1	2	3	4	5	6
Fatigue or Low Energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble Falling Asleep	0	1	2	3	4	5	6
More Emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6