Intake

Informant/Relationship

Chief Complaint

Vitals

Weight		lbs		oz		+
Height		in				+
BMI		kg/m²				
Blood Pressure	/	systolic/diastolic	Location	Unspecified	Position	Unspecified +
Pulse		beats per minute				+
Temperature		°F	Method	Unspecified		+
O_2 Saturation		%				+

More

Current Medications

History of Present Illness

Date and time of injury?

notes

Mechanism of injury?

notes

Location and nature of pain?

notes

Swelling, bruising, redness, or deformity?

notes

Loss of Consciousness?

notes

Nausea or Vomiting?

notes

Lethargy?

notes

Any treatment (ice, medication, etc.)?

notes

ER or other medical attention?

notes

Other Injuries?

notes

Other Notes

notes

History

Select All

- [ ] Medication Record (reviewed and updated)

notes

- [ ] OTC meds/herbal meds/CAM used (notes below)

notes

- [ ] add item

notes

Transition of Care (ARRA)

- [ ] Patient transitioned to my care from another clinical setting
- [ ] Medication Reconciliation performed

Review of Systems

Make All: **Pos** **Neg** **N/A**

Pos	Neg	N/A		
○	○	○	Headache	notes
○	○	○	Dizziness	notes
○	○	○	Visual changes	notes
○	○	○	Memory loss	notes
○	○	○	Retrograde amnesia (any events just BEFORE the injury that there is no memory of (even brief))	notes
○	○	○	Anterograde amnesis (any event just AFTER the injury that there is no memory of (even brief))	notes
○	○	○	Mental status changes	notes
○	○	○	Seizures	notes

Pos Neg N/A

Behavioral changes

notes

School problems

notes

add item

notes

Past Medical/Social/Family History

Select All

Hx of Injury

notes

add item

notes

Medical History (Medical Summary) No Saved Notes **Edit**

Family History (Medical Summary) No Saved Notes **Edit**

Social History (Medical Summary) No Saved Notes **Edit**

Concussion - Risk Factors for Protracted Recovery

Make All: **Yes** **No** **N/A**

Yes No N/A

Concussion history (note number)

notes

Longest symptom duration (days, weeks, months, years?)

notes

If multiple concussions, less force caused reinjury?

notes

Headache history?

notes

Prior treatment for headache?

notes

History of migrane headache - personal?

notes

History of migraine headache - family?

notes

History of learning disabilities?

notes

Yes No N/A

History of ADD/ADHD?

notes

History of other developmental disorder?

notes

History of anxiety?

notes

History of depression?

notes

History of sleep disorder?

notes

History of other psychiatric disorder?

notes

Other comorbid medical disorders or medication usage? (eg hypothyroid, seizures)

notes

add item

notes

Concussion Symptom Checklist

Make All: **No** **Yes** **N/A**

No Yes N/A

Headache

notes

Nausea

notes

Vomiting

notes

Balance Problems

notes

Dizziness

notes

Visual Problems
notes

Fatigue
notes

Sensitivity to light
notes

No Yes N/A

Sensitivity to noise
notes

Numbness/Tingling
notes

Feeling mentally foggy
notes

Feeling slowed down
notes

Difficulty concentrating
notes

Difficulty remembering
notes

Irritability
notes

Sadness
notes

No Yes N/A

More emotional
notes

Nervousness
notes

Drowsiness
notes

Sleeping less than usual
notes

Sleeping more than usual
notes

Trouble falling asleep
notes

Do these symptoms worsen with physical activity?
notes

Do these symptoms worsen with cognitive activity?
notes

No Yes N/A
add item
notes

Physical Exam

Make All: **A** **N** **N/E**

A N N/E

General Appearance
notes

Head
notes

Eyes
notes

Ears
notes

Nose
notes

Oropharynx
notes

Neck
notes

Chest
notes

A N N/E

Cardiovascular
notes

Abdomen
notes

Neurologic
notes

Appears dazed or stunned

notes

Is confused about events

notes

Answers questions slowly

notes

Repeats questions

notes

Forgetful (recent info)

notes

A N N/E

Skin

notes

add item

notes

Diagnoses

Headache (784.0)

notes

Add to Problem List Onset: mm/dd/yy Problem Note: problem note

Concussion (850.9)

notes

Add to Problem List Onset: mm/dd/yy Problem Note: problem note

add diagnosis

notes

Diagnosis Notes

Plan

Select All

- [ ] Pain Management (include medication recommended)
  - notes
- [ ] Medication as e-prescribed
  - notes
- [ ] Note to return to school
  - notes
- [ ] add item
  - notes

Parent/Patient Understanding

Make All: Gd Fr Pr

	Gd	Fr	Pr
Parent understanding	○	○	○
Patient understanding	○	○	○

- notes
- notes

add item

notes

Immunizations

Immunization History

	There are no immunizations recorded for this patient
Ordered	

Immunization Orders

Order | Refuse | select an immunization

Immunization Notes

Make All: **Yes** **No** **NA**

Yes No NA

Immunization informed consent

notes

add item

notes

Medical Procedure

Lab

Radiology

Order Head CT

Referral

Order Emergency Room

Order Sports Medicine

Order Neurology

Followup

Order As needed

Order Return to office (list reason and time frame)

Order by Phone (list reason and time frame)

Order by Phone (nurse call to check on)

Additional Notes