Date Injury Occurred (mm/dd/yyyy):

Time of Injury (24 hour clock):

Day of week of injury:

[ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Sunday

Source of information: [ ] Clinician

 [ ] Player [ ]  Parent [ ]  Coach [ ]  Other

## Reliability of injury data: [ ] Verified [ ] Estimated [ ] Unknown

1. Who was the clinical assessment completed by?

[ ] Athletic Trainer [ ] Coach [ ]  Physicians Assistant

[ ] Medical Doctor [ ] Physical Therapist [ ]  Other

1. How confident was clinician that injury was a concussion?

[ ] Not at all Confident [ ] Barely Confident [ ] Somewhat Confident

[ ] Fairly Confident [ ] Very Confident

1. If injury data is ESTIMATED, injury data type (point in time):

[ ] Time participant became symptomatic

[ ] Time of first trauma activation

[ ] Time of presentation to emergency dept

1. How many hours after the injury did the first evaluation take place?
2. How many hours after the injury did the second evaluation take place?
3. How many hours after the injury did the third evaluation take place?
4. Does subject have a baseline? [ ] Yes [ ] No
5. Was athlete taken out of game? [ ] Yes [ ] No
6. Did the athlete immediately report the injury? [ ] Yes [ ] No
	1. If no, how many minutes/hours after injury did athlete report it to someone?
7. Did athlete continue participation after suspected injury event? [ ] Yes [ ] No
	1. If so, for how long?
	2. For how many plays?
8. Did athlete go to ER? [ ] Yes [ ] No
9. Treated at hospital before study center? [ ] Yes [ ] No
10. Date treated at hospital: mm/dd/yyyy
11. Time treated at hospital: 24 hour clock
12. Hospital admission date:

 [ ]  NA

1. Hospital admission time (mm/dd/yyyy; 24 hour clock):
2. Symptom onset date: mm/dd/yyyy
3. Symptom onset time: 24 hr clock
4. Were initial medical services received immediately after injury? [ ] Yes [ ] No [ ] Unknown
5. Medical Services received:

[ ] CT/MRI

[ ] Hospitalization

[ ] Specialized therapies

[ ] Evaluation (neuro, psych)

[ ] Medications

[ ] Education on symptoms or course of injury

[ ] Other, specify:

1. At the time of injury, was any protective equipment worn? Helmet, mouthguard, tape, brace, other
2. Sport at time of injury
3. Position at time of injury
4. Injury occurred during: Game, practice, dryland/fitness, other
5. Injury involved: Sudden onset and contact with another player; sudden onset and no contact with another player; Gradual onset/overuse; unknown
6. Cause of injury (will depend on sport) – body check, tackle, intentional player contact (elbowing, roughing, cross-check, dueling for header, etc)
7. Mechanism of injury: direct blow to head, fell and hit head, hit head on environment, non head injury
8. Was a penalty called directly related to the injury event: Yes/no if yes, describe; who received penalty
9. Describe events surrounding the injury:
10. Injury location for each type of injury (often more than one injury at time of injury- list of all injury types and body parts)
11. Mechanism of Injury: [ ]  Contact with another player [ ]  Impact with ground [ ]  Impact with object (i.e. ball)
12. Likelihood participant under influence of alcohol:

[ ] None [ ] Suspected [ ] Confirmed [ ] Unknown

1. Location of impact:

[ ] Frontal

[ ] L temporal

[ ] R temporal

[ ] L parietal

[ ] R parietal

[ ] Occipital

[ ] Neck

[ ] Indirect force

1. Injury Description:

SYMPTOMS

1. Loss of consciousness [ ] Yes [ ] No
	1. Duration: [ ] < 1 min [ ] 1-30 min [ ] 30 - 24 hr
2. Dizziness [ ] Yes [ ] No
	1. Duration: [ ] 0-1hr [ ] 1-24hr [ ] >24hr
3. Retrograde amnesia [ ] Yes [ ] No
	1. Duration: [ ] 0-1hr [ ] 1-24hr [ ] >24hr
4. Amnesia of event [ ] Yes [ ] No
	1. Duration: [ ] 0-1hr [ ] 1-24hr [ ] >24hr
5. Post traumatic amnesia [ ] Yes [ ] No
	1. Duration: [ ] 0-1hr [ ] 1-24hr [ ] >24hr
6. Confusion/disorientation [ ] Yes [ ] No
7. How long did symptoms last after injury/impact? days, hours, minutes
8. Symptoms:

[ ] Dizziness

[ ] Off-balance

[ ] Fogginess/ confusion

[ ] Nausea/vomiting

[ ] Memory loss

[ ] Vision changes

[ ] Headache

1. Baseline headache impact test-6 (HIT-6)
2. Follow-up headache impact test-6 (HIT-6)
3. Brain imaging abnormality: [ ] Yes [ ] No [ ] No imaging
	1. Type of imaging:
4. Pain Assessment :

 **Faces Rating Scale (Wong Baker):**



**Explanation:**

* For use with ages 4 and older
* Explain to the child that each face is for a person who feels happy because he has no pain (hurt), or sad because he has some or a lot of pain

Face 0 is very happy because he doesn’t hurt at all.

Face 2 hurts just a little bit

Face 4 hurts a little more

Face 6 hurts even more

Face 10 hurts as much as you can imagine

Ask the child to choose the face that best describes how he/she is feeling.

0=no pain 1–3=mild pain        4=moderate pain   7–10=severe pain

**0–10 Numeric Pain Rating Scale:**



**Explanation:**

* For use with ages 8 and older
* Explain to the child that at one end of the line is 0, which means that a person feels no pain (hurt). At the other end is a 10, which means the person feels the worst pain imaginable. The numbers 1 to 9 are for a very little pain to a whole lot. Ask the child to choose the number that best describes how he/she is feeling.

0=no pain       1–3=mild pain        4=moderate pain   7–10=severe pain

Visual Analog Scale (0-10) – Mark ’X’ to area on the line with 0 being no pain to 10 being the worst pain.

 0 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10

1. Suicidal Ideation

ORTHOPEDIC INJURIES

1. Did/Does Athlete Have any Other Orthopedic Injuries? [ ] Yes [ ] No
	1. Head (Non-Concussive) [ ] Yes [ ] No
	2. Neck [ ] Yes [ ] No [ ]  Sore but not injured
	3. Shoulder [ ] Yes [ ] No
	4. Arm/Elbow [ ] Yes [ ] No
	5. Wrist/Hand/Fingers [ ] Yes [ ] No
	6. Back [ ] Yes [ ] No
	7. Trunk [ ] Yes [ ] No
	8. Hip/Thigh [ ] Yes [ ] No
	9. Knee [ ] Yes [ ] No
	10. Lower Leg/Foot/Toe [ ] Yes [ ] No

REPEAT INJURY

1. Repeat concussion this year

POST-INJURY STATUS

1. Return to work/school:

[ ] Returned to previous level

[ ] Same work or school, reduced level

[ ] Different work or school

[ ] Only in sheltered environment

[ ] Did not return to work or school

[ ] N/A

[ ] Unknown

1. Injury ICD external cause code:

OTHER INFORMATION

1. Approximately how many days of school has the child missed?

 [ ] 0 [ ] 1-2 days [ ] 3-6 days [ ] 7+ days

1. Please indicate the grade that your child is currently enrolled in:

[ ] Kindergarten

[ ] Grade 1

[ ] Grade 2

[ ] Grade 3

[ ] Grade 4

[ ] Grade 5

[ ] Grade 6

[ ] Grade 7

[ ] Grade 8

[ ] Grade 9

[ ] Grade 10

[ ] Grade 11

[ ] Grade 12

[ ] Not currently enrolled

[ ] Other, Specify:

1. Please indicate your child's average academic achievement prior to the concussion:

[ ] Straight A student

[ ] A & B grades

[ ] Straight B student

[ ] B & C grades

[ ] Below C grades

1. Has your child had a CT or MRI for a PREVIOUS head injury? [ ] Yes [ ] No [ ] Unknown
2. Has your child been hospitalized for a previous head injury? [ ] Yes [ ] No [ ] Unknown
3. Has your child received any medication since the time of their injury? [ ] Yes [ ] No
	1. Specify which medication(s) your child received since the time of their injury. Check all that apply:

[ ] Acetaminophen (Tylenol, Tempra)

[ ] Ibuprophen (Advil, Motrin)

[ ] Gravol

[ ] Other, Specify:

1. After your child's head injury did he/she have a seizure? [ ] Yes [ ] No
2. Current academic year in which your child will be participating in enrolled sport:

[ ] 6th grade

[ ] 7th grade

[ ] 8th Grade

[ ] HS-Fr

[ ] HS-So

[ ] HS-Jr

[ ] HS-Sr

[ ] College-Fr

[ ] College-So

[ ] College-Jr

[ ] College-Sr

[ ] College-5th Yr
[ ] College-6th Yr

(i.e. baseline test in spring or summer for fb, academic year is what they will be when participating in sport in fall)

1. Does your child have a history of Special Education? For example, have you had any special classes or accommodations in school? [ ] No [ ] Yes [ ] Unknown
2. Have you ever had an IEP (Individualized Education Program) or extra support for studies? [ ] No [ ] Yes [ ] Unknown
	1. If yes, what did you have an IEP in? [ ] Reading [ ] Writing [ ] Math [ ] Other
3. What type of student were/are you in high school?

[ ] Below Average
[ ] Average
[ ] Above Average

## General Instructions

Important note: None of the data elements on this CRF Module are considered Core (i.e., strongly recommended for all sports-related concussion clinical studies to collect). They are supplemental and should only be collected if the research team considers them appropriate for their study.

## Specific Instructions

*Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.*