HeadSmart™
SPORTS CONCUSSION PROGRAMME
AUSTRALIA · SOUTH AFRICA · UK

HEADSMART™ SPORTS CONCUSSION PROGRAMME

RISK PROFILING

Athlete / Player Name: ________________________________ **Gender:**

DOB: ________ **Age:** ___ **Name of School / Club:** ________________________________

Today's date: __________ **Most recent head injury:** __________

CONTACT DETAILS

Address: ________________________________ **State:** ________ **Postcode:** ________

Mobile: ____________________ **Email:** ________________________________

SPORTS PARTICIPATION

Sport/s

- ☐ No Sport
- ☐ Abseiling
- ☐ Archery
- ☐ Adventure Racing
- ☐ Australian Rules
- ☐ Badminton
- ☐ Basketball
- ☐ Baseball
- ☐ Beach Volleyball
- ☐ Biathlon
- ☐ BMX
- ☐ Bodybuilding
- ☐ Bowls
- ☐ Boxing
- ☐ Canoe
- ☐ Climbing
- ☐ Cheerleading
- ☐ Cricket
- ☐ Cross Country
- ☐ Cross Country Ski
- ☐ Cross Fit
- ☐ Cycling / Road Track
- ☐ Darts
- ☐ Diving
- ☐ Equestrian
- ☐ Extreme Sport
- ☐ Fishing Deep Sea
- ☐ Futsal
- ☐ Golf
- ☐ Gymnastics
- ☐ Hapkido
- ☐ Hiking
- ☐ Horse riding / racing
- ☐ Ice Skating / Dancing
- ☐ Judo
- ☐ Karate
- ☐ Kayak
- ☐ Lacrosse
- ☐ Mixed Martial Arts
- ☐ Motor Sports
- ☐ Moto X
- ☐ Mountain Bike
- ☐ Netball
- ☐ Paralympic
- ☐ Polo Cross
- ☐ Powerlifting
- ☐ Race Walking
- ☐ Road Running
- ☐ Rodeo
- ☐ Roller Sport / Derby
- ☐ Rubber Ducking
- ☐ Rugby League
- ☐ Rugby Union
- ☐ Sailing
- ☐ Skateboarding
- ☐ Skydiving
- ☐ Slalom
- ☐ Snooker Billiards
- ☐ Snorkeling
- ☐ Snow Sports
- ☐ Soccer
- ☐ Softball
- ☐ Stand Up Paddle boarding
- ☐ Surfing
- ☐ Surf Lifesaving
- ☐ Surf ski
- ☐ Swimming
- ☐ Table Tennis
- ☐ Tennis
- ☐ Touch Football
- ☐ Track & Field
- ☐ Trail Running
- ☐ Triathlon
- ☐ UFC
- ☐ Volleyball
- ☐ Walking Endurance
- ☐ Watersports
- ☐ Weightlifting
- ☐ Wrestling
- ☐ Yachting
- ☐ Other: ______________

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Other sports/activities: ____

Level of participation

- ☐ Recreational
- ☐ School
- ☐ Club
- (Name:________________)
- ☐ Regional
- ☐ State
- ☐ National
- ☐ International
- ☐ Professional

BASELINE SYMPTOM ASSESSMENT

What, if any, symptoms present on most days of the week and rate their severity?

Headache
☐ None ☐ Mild ☐ Moderate ☐ Severe

Loss of appetite or nausea
☐ None ☐ Mild ☐ Moderate ☐ Severe

Dizziness or head spinning
☐ None ☐ Mild ☐ Moderate ☐ Severe

Blurred vision
☐ None ☐ Mild ☐ Moderate ☐ Severe

Balance difficulty
☐ None ☐ Mild ☐ Moderate ☐ Severe

Sensitivity to bright light
☐ None ☐ Mild ☐ Moderate ☐ Severe

Sensitivity to loud noise
☐ None ☐ Mild ☐ Moderate ☐ Severe

Trouble staying focused
☐ None ☐ Mild ☐ Moderate ☐ Severe

Memory difficulty or loss
☐ None ☐ Mild ☐ Moderate ☐ Severe

Low energy or tiredness
☐ None ☐ Mild ☐ Moderate ☐ Severe

Confused or disorientated
☐ None ☐ Mild ☐ Moderate ☐ Severe

Sleeping pattern change
☐ None ☐ Mild ☐ Moderate ☐ Severe

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Feeling down or unhappy
☐ None ☐ Mild ☐ Moderate ☐ Severe

Feeling tense or anxious
☐ None ☐ Mild ☐ Moderate ☐ Severe

Feeling generally unwell
☐ None ☐ Mild ☐ Moderate ☐ Severe

Other symptoms not listed? ____

PAST CONCUSSIONS

If relevant, which symptoms have you had when concussed?

Headache
☐ None ☐ Mild ☐ Moderate ☐ Severe

Loss of appetite or nausea
☐ None ☐ Mild ☐ Moderate ☐ Severe

Dizziness or head spinning
☐ None ☐ Mild ☐ Moderate ☐ Severe

Blurred vision
☐ None ☐ Mild ☐ Moderate ☐ Severe

Balance difficulty
☐ None ☐ Mild ☐ Moderate ☐ Severe

Sensitivity to bright light
☐ None ☐ Mild ☐ Moderate ☐ Severe

Sensitivity to loud noise
☐ None ☐ Mild ☐ Moderate ☐ Severe

Trouble staying focused
☐ None ☐ Mild ☐ Moderate ☐ Severe

Memory difficulty or loss
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Sleeping pattern change

☐ None ☐ Mild ☐ Moderate ☐ Severe

Feeling down or unhappy

☐ None ☐ Mild ☐ Moderate ☐ Severe

Feeling tense or anxious

☐ None ☐ Mild ☐ Moderate ☐ Severe

Feeling generally unwell

☐ None ☐ Mild ☐ Moderate ☐ Severe

Other symptoms not listed? ____

Does thinking activity worsen reported symptoms?

- ☐ Yes
- ☐ No

Which symptoms? ____

Does exercise activity worsen reported symptoms?

- ☐ Yes
- ☐ No

Which symptoms? ____

Reported symptoms from previous concussion?

- ☐ Yes
- ☐ No

Which symptoms? ____

Do have have any of the following (tick all appropriate)?

- ☐ Ehlers Danlos syndrome
- ☐ Family history of retinal detachment
- ☐ Far sighted
- ☐ Hypermobility syndrome
- ☐ Knoboch syndrome
- ☐ Marfan's syndrome
- ☐ Marshall
- ☐ Near sighted
- ☐ Stickler syndrome

Do have have any of the following (tick all appropriate)?

- ☐ ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ Dyslexia
- ☐ Learning disorder

List medications required daily or most days (tick all appropriate)

- ☐ Anti depressants
- ☐ Anti inflammatories
- ☐ Mood stabilisers
- ☐ Muscle relaxants

PAST CONCUSSIONS

Have you had past concussions? Yes / No

Sport played at time: ________________________ **Concussion date:** _____________

Treatment ____

____

Days off work/school: __________ **Days off exercise:** ___________ **Days off sport:** _____________

Had any other concussions? Yes / No

Date 3rd concussion: _________ **Date 4th concussion:** __________ **Date 5th concussion:** ___________

Treatment ____

____

ATHLETE / PLAYER PRIVACY

- ✓ I have read and accepted the website terms and conditions.
- ✓ I consent that anonymous data may be collected for research purposes.

Signed ____ **Todays date:** ____________________

Your email address ____

Co-ordinator's email address: ____

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