



PAST SPORT/ACTIVITY PARTICIPATION

Please fill out the forms below and provide as much information as you can regard your past sport participation. Please fill out the team name, beginning date of association with the team to the end date of association with the team and the number of suspected or diagnosed concussion that you have had during that time.

Professional Football Team(s) Played for

Team Name	From	To	# of Concussions

Which of the following positions did you play professionally?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Quarterback | <input type="checkbox"/> Center | <input type="checkbox"/> Full back | <input type="checkbox"/> Cornerback |
| <input type="checkbox"/> Tight end | <input type="checkbox"/> Left/Right guard | <input type="checkbox"/> Left/Right tackle | <input type="checkbox"/> Kicker |
| <input type="checkbox"/> Defensive tackle | <input type="checkbox"/> Defensive end | <input type="checkbox"/> Linebacker | <input type="checkbox"/> Offensive Back |
| <input type="checkbox"/> Safety | <input type="checkbox"/> Running back | <input type="checkbox"/> Wide receiver | |

How many total years did you play professional football? _____

What year did you retire? _____

What was the reason for leaving the League?

How many times did you try to get back in the league? _____



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Other Sports

Sport	Level (Professional, College, High School, Pre-High School)	Years played	Position(s)	Number of Concussions

Have you ever had any head trauma/ding(s)/bell ringers/concussions?: No Yes Total# _____



Employment History

Job Title	Name of Business	Date Worked From	Date Worked To

Have you served in the military? No Yes

If yes, dates of service _____

Which branch? _____

What type of discharge did you receive? _____

What type of work did you do? _____

Did you obtain any training while in the military? _____

BRIEF SOCIAL HISTORY: Please answer the following questions.

In what city were you born?

In what city did you graduate from high school?

Where did you go to college? _____

Were there any major moves between your birth and high school graduation? _____



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Describe your history of relationships with supervisors:

Describe your history of relationships with co-workers:

Describe your history of relationships with supervisees:

Describe your relationships with friends:

Describe your relationships with your children:

Describe your relationships with your spouse:

How long have you been married? _____



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How many brothers do you have? _____ Ages? _____

How many sisters do you have? _____ Ages? _____

Please describe your hobbies.

Please describe any personal or professional goals that you have. _____

Income (NINDS SES)

1. What was the average of your parents combined income from birth to age 18?

\$ _____

2. What is your average income?

\$ _____

3. What is your spouse's average income (if applicable)?

\$ _____

4. What is your household's net worth (include major assets such as savings, houses, and cars)?

\$ _____



Education

1. What was your score on the ACT/SAT (or equivalent) ? _____
2. What was your cumulative GPA in high school? _____
3. What was your cumulative GPA in college ? _____
4. What is your highest level of educational attainment (Please select one)?
 - No Schooling Completed
 - 10th Grade
 - 11th Grade
 - 12th Grade; No Diploma
 - High School Graduate (Includes Equivalency)
 - Some College, Less Than 1 Year
 - Some College; 1 or More Years, No Degree
 - Associate Degree
 - Bachelor's Degree
 - Master's Degree
 - Professional Degree
 - Doctorate Degree

What is/was your **mother's** education level (Please select one)?

- No Schooling Completed
- 10th Grade
- 11th Grade
- 12th Grade; No Diploma
- High School Graduate (Includes Equivalency)
- Some College, Less Than 1 Year
- Some College; 1 or More Years, No Degree
- Associate Degree
- Bachelor's Degree
- Master's Degree
- Professional Degree
- Doctorate Degree



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What is/was your **mother's** occupation? _____

What is/was your **father's** education level (Please select one)?

- No Schooling Completed
- 10th Grade
- 11th Grade
- 12th Grade; No Diploma
- High School Graduate (Includes Equivalency)
- Some College, Less Than 1 Year
- Some College; 1 or More Years, No Degree
- Associate Degree
- Bachelor's Degree
- Master's Degree
- Professional Degree
- Doctorate Degree

What is/was your father's occupation? _____

Are your parents: Married Separated Divorced

Please describe your relationship with your mother during childhood.

Please describe your relationship with your mother now.

Please describe your relationship with your father during childhood.

Please describe your relationship with your father during now.



Please describe your relationship with your siblings during childhood.

Please describe your relationship with your siblings now.

Learning/Education Background: Please provide the following information regarding how you learn best and the level of education that you have completed.

- Do you learn best by: Reading Listening Seeing a demonstration
 Other _____
 - Have you received special education services? No Yes.
If yes, in what grades and subjects? _____
 - Have you been placed in any honors classes/programs? No Yes
 - If yes, in what grades and subjects? _____

- Do you have a hearing Impairment? No Yes.

- If yes, do you wear hearing aids? No Yes.

- Do you wear glasses and/or contacts? No Yes

- How many years of education have you completed (including high school)? _____

- Did you graduate from high school? No Yes If yes, what year did you graduate? _____

- Did you graduate from college? No Yes If yes, what year did you graduate? _____
What degree did you graduate with? _____
If no, would you be/are you interested in finishing your degree? No Yes



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PAST TESTING: If you have had any testing done in the past, please bring any copies, reports, etc to your visit (**opportunity to send a release of medical records and obtain medical records prior to visit*)

Have you ever had any neurological imaging (MRI, CT-scan, etc) in the past?: No Yes. If yes, please provides **dates** and for **what reason**.

Have you ever had any computerized neuropsychological testing (ImPACT, concussion vital signs, etc) in the past?: No Yes. If yes, please provides dates and for what reason.

Have you ever had an electroencephalogram (EEG) (**Brain Wave Test**) in the past?: No Yes. If yes, please provides dates and for what reason.

Have you ever blood work done in the past?: No Yes. If yes, please provides dates and for what reason.



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Do you have any of the symptoms listed below?

	Symptoms	
	Yes (please clarify)	No
Poor appetite		
Excessive appetite		
Fatigue		
Excessive energy		
Difficulty solving problems		
Problems with motor coordination		
Difficulty expressing yourself		
Difficulty understanding conversation		
Problems with speech		
Do you have any other problems expressing yourself		
Problems concentrating		

PERCEIVED STRESS: The following questions ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because
of something that happened unexpectedly?..... 0 1 2 3 4
2. In the last month, how often have you felt that you were unable
to control the important things in your life?0 1 2 3 4
3. In the last month, how often have you felt nervous and "stressed"?0 1 2 3 4
4. In the last month, how often have you felt confident about your ability
to handle your personal problems? 0 1 2 3 4
5. In the last month, how often have you felt that things
were going your way?..... 0 1 2 3 4
6. In the last month, how often have you found that you could not cope
with all the things that you had to do? 0 1 2 3 4
7. In the last month, how often have you been able
to control irritations in your life?..... 0 1 2 3 4
8. In the last month, how often have you felt that you were on top of things?.....0 1 2 3 4
9. In the last month, how often have you been angered
because of things that were outside of your control?..... 0 1 2 3 4
10. In the last month, how often have you felt difficulties
were piling up so high that you could not overcome them?0 1 2 3 4



Please circle any of the following which are **currently stressful** for you.

Family Conflicts

Conflicts with Friends

Unemployment

Housing Problems

Problems at Work

Legal Problems

Financial Problems

Academic Problems

Problems Obtaining Health Care Services

Chronic Pain

Other Medical Problems

Other_____

If you circled any of the above stressors, please explain

Have you ever experienced any significant emotional trauma(s)? No Yes If yes, please describe_____

Approximately when did this/these event(s) occur?



MEDICAL HISTORY

A. Past Medical History

Have you or your immediate family (blood relatives – parents, grandparents, sisters, brothers) had any of the conditions listed below?

	Self		Family	
	Yes (please clarify)	No	Yes (Which relative(s) and age of onset?)	No
Dementia/Alzheimer's				
Parkinson's Disease				
Stroke				
Blackouts/Fainting				
Epilepsy/Seizure				
Reading/Learning Disabilities				
Attention deficit disorder/attention deficit hyperactivity disorder				
Birth complications				
Migraine headaches				
Head/Spine Trauma				
Depression/Anxiety				
Sleep disturbance				
Alcohol/substance abuse				
Suicidal thoughts/ attempts				
Asthma				
Thyroid problems				
High blood pressure				



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	Self		Family	
High cholesterol/fat				
Heart Attack				
Heart valve defect				
Hepatitis/liver disease				
Kidney disease				
Bladder problems				
Diabetes				
Sudden Death				
Arthritis				
Cancer: <input type="checkbox"/> Colon <input type="checkbox"/> Breast/ Ovarian				
Sickle cell anemia				
HIV/AIDS				
Weight gain/loss (>15lbs in past 6 months)				
Genetic disorders				
Learning problems				
Other(s):				

Comments:

How often do you wear a seatbelt? _____ (opportunity for patient education)

Are there any firearms kept in your home? Yes No (opportunity for patient education)



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List any other medical issues and injuries not listed, that you have:

Surgical History: Please provide as much information about each surgery as you know

/		
/		
/		
/		

Medications: Please provide the following information for all medications that you have ever taken. The first table is for medications that you are currently taking. The second table is for medications that you have taken in the past but no longer take.

Current Medications:

Medicine	Reason for taking	Dosage	Amount



Past medications for problems that are no longer active:

Medicine	Reason for taking	Dosage	Amount

Do you have any allergies? Yes No

Please any allergies that you have. Include any medicines, foods, seasonal allergies, etc and provide all information that you know.

Allergen	Reaction (Anaphylaxis, swelling, itching, vomiting, etc)	List anything used to treat reaction (i.e. epipen, medications, etc)

Functional. Are you having difficulties with any of the following (check all that apply)

- eating bathing dressing toileting transferring (walking)
continenence working driving shopping for food
cooking difficulties with finances difficulties with balancing checkbook
difficulties with compliance with medications or appointments.

Specify: _____



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History of Seizures: Have you ever had a seizure?

No Yes If Yes, please answer the following questions,

- What was the date of the first seizure? _____
- What type of seizure was it? _____
- What was the date of your last seizure? _____
- Are you currently under the care of a physician for your seizure? No Yes If yes, please describe

- Are you currently taking any medication for your seizure? No Yes If yes, please describe

History of stroke: Have you ever had a stroke?

No Yes If Yes, please answer the following questions

- What was the date of stroke(s): _____
- Was there any brain surgery as a result of the stroke? No Yes If yes, please describe

- Are there any impairments as a result of the stroke? No Yes If yes, please describe

- Are you currently under the care of a physician for your stroke? No Yes If yes, please describe



History of motor vehicle accident: Have you ever been in a motor vehicle accident?

No Yes If Yes, please answer the following questions.

- What was the date of accident(s): _____
- Was there any head trauma as a result of the accident? No Yes. If yes, please describe.

- Was there any brain surgery as a result of the accident? No Yes. If yes, please describe

- Are there any impairments as a result of the accident? No Yes. If yes, please describe

DEVELOPMENTAL HISTORY/ CHILDHOOD PAST MEDICAL HISTORY

Please provide as much information as you know about your childbirth and any early childhood illnesses that you have had.

Were there any complications during your mother's pregnancy with you or with your birth?

No Yes If Yes, please describe below

Describe: _____

Did your mother take any medicines or use any other substances during her pregnancy with you?

No Yes If Yes, please describe below

Describe: _____

Did you have any early childhood illnesses?

No Yes If Yes, please describe below

Describe: _____



Did you have, or do you currently have any reading or other learning disabilities?

No Yes If Yes, please describe below

Describe: _____

Handedness scale: Please fill out the following chart based on what hand you would use to complete the tasks in the left hand column.

Stimuli to determine handedness (Kertesz, 1979, p.56)

	Which hand do you prefer for:		
2	Throwing	Left	Right
3	Cutting	Left	Right
4	Drawing	Left	Right
5	Brushing	Left	Right
6	Using a Spoon	Left	Right

SUBSTANCE USE HISTORY:

Alcohol: Do you use Alcohol?

No Yes, If yes, answer the following questions:

- How old were you when you first drank?_____ How many days per week to you drink alcohol? __
- How many drinks do you typically have when you do drink?_____
- During a typical month, are there any occasions when you drink more than 5 drinks in 2 hours?
 No Yes
- Do you have a history of blackouts, delirium tremens (shaking due to alcohol withdrawal), and/or alcohol-related seizures: No Yes
- Since you first started drinking, what is the longest period of time you have gone without drinking?:_____
- Do you consider yourself sober now? No Yes
- When was the last time when you consumed alcohol?_____

Nicotine: Within the last month, have you used any tobacco products or products that contain nicotine?

No Yes, If yes, answer the questions below:

- What type do you use? _____How old were you when you first used? _____
- How much (packs, cans, cigars, etc) do you use per day? _____/day
- When was the last time that you used any tobacco or nicotine products? _____



Performance Enhancing Drugs: Have you ever used steroids, growth hormone, blood doping, or any other performance enhancing drugs?

No

Yes, if Yes answer the following questions:

- What type did you use? _____ How old were you when you first used? _____
- How long did you use them? _____
- For what purpose did you use them? _____
- When was the last time that you used them? _____

C. Substance Use History

Substance/Drug	Ever tried?	Method of Use (inject, smoke, etc.)	Currently use?	Avg daily use	Avg weekly use
Methamphetamine	Y / N Age first used:		Y / N Date last use:		
Cocaine	Y / N Age first used:		Y / N Date last use:		
Marijuana	Y/N Age first used:		Y / N Date last use:		
Sedatives (downers): sleeping pills, barbituates, benzos (Xanax)	Y / N Age first used:		Y / N Date last use:		
Dissociative/ club drugs: ecstasy, ketamine, PCP	Y / N Age first used:		Y / N Date last use:		
Opiates: heroin, morphine, codeine, Vicodin	Y / N Age first used:		Y / N Date last use:		
Hallucinogens: LSD/acid, mushrooms, peyote/mescaline	Y / N Age first used:		Y / N Date last use:		
Other(s):	Y / N Age first used:		Y / N Date last use:		



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Comments on Substance Use History:

PSYCHIATRIC HISTORY:

Have you ever had in psychiatric, psychotherapy, or counseling in the past? No Yes. If yes, please provide the **dates** you received the services and details about what **conditions and treatments** you received.

Have you ever had any hospitalizations for any psychiatric reasons? No Yes. If yes, please provide approximately when these hospitalizations occurred and the details.

Have you ever experienced suicidal thoughts? No Yes

Are you currently experiencing suicidal thoughts? No Yes

Have you ever attempted suicide? No Yes. If yes, approximately when did the event occur?

Did/do you have a method of choice for suicide? No Yes

Do you have any history of aggressive or violent behavior? No Yes. If yes, please provide details.



Have you ever had a restraining order or any other criminal justice contact? No Yes. If yes, please provide details.

CARDIOVASCULAR FACTORS

Did your mother and/or father suffer a heart attack before age 60? No Yes. If yes, please state at what age the cardiovascular event happened.

Have **YOU** ever had any of the following atherosclerotic heart or blood vessel disease events?

Event	Yes	No
Transient Ischemic Attack (TIA)		
Angioplasty or balloon plasty		
Coronary artery bypass graft (CABG)		
Peripheral Artery Disease		
Surgery for a circulation problem (legs)		
Carotid artery disease		
Stent Procedure		
Angina		
Heart Attack		
Stroke		

Do you currently smoke? No Yes

If yes, how much do you smoke (packs/week)? _____



Current Physical Activity (Godin Leisure-Time Exercise Questionnaire, Godin and Shephard, 1985)

During a typical 7-Day period (a week), how many times on the average do you do the following kinds of exercise for more than 15 minutes during your free time?

Write on each line the appropriate number of times per week.

a) STRENUOUS EXERCISE (HEART BEATS RAPIDLY) ____/week.

(e.g., running, jogging, hockey, football, soccer, squash, basketball, cross country skiing, judo, roller skating, vigorous swimming, vigorous long distance bicycling)

b) MODERATE EXERCISE (NOT EXHAUSTING) ____/week.

(e.g., fast walking, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, popular and folk dancing)

c) MILD EXERCISE (MINIMAL EFFORT) ____/week.

(e.g., yoga, archery, fishing from river bank, bowling, horseshoes, golf, snow-mobiling, easy walking)

During a typical 7-Day period (a week), in your leisure time, how often do you engage in any regular activity long enough to work up a sweat (heart beats rapidly)? Circle one.

OFTEN SOMETIMES NEVER/RARELY

CURRENT SOCIAL LEISURE ACTIVITY (NINDS COMMON DATA ELEMENTS)

INDICATE ANY OR ALL OF THE FOLLOWING TYPES OF SOCIAL OR VOLUNTARY ACTIVITIES YOU HAVE PARTICIPATED IN OR DONE IN THE LAST MONTH.

Done voluntary or charity work _____

Cared for a sick or disabled adult _____

Provided help to family, friends or neighbors _____

Attended an educational or training course _____

Gone to a sport, social or other kind of club _____

Taken part in a religious organization (church, synagogue, mosque etc.) _____

Taken part in a political or community-related organization _____

None of these _____



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**Current Cognitive Leisure Activity (Adapted from Lifetime of Experience Questionnaire (LEQ),
Valezuela & Sachdev, 2007)**

How often do you practice or play a musical instrument?

Daily Weekly Bi-monthly Monthly Less than monthly Never

How often would you practice or develop an artistic pastime (e.g. drawing, painting, writing, acting)?

Daily Weekly Bi-monthly Monthly Less than monthly Never

How often do you read (material of any sort) for more than five minutes?

Daily Weekly Bi-monthly Monthly Less than monthly Never

How often do you practice speaking a second language?

Daily Weekly Bi-monthly Monthly Less than monthly Never

Do you have any other pastime, hobby or special interest not mentioned in this questionnaire?



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use “✓” to indicate your answer)

Not at all

Several days

More than half the days

Nearly every day

1. Little interest or pleasure in doing things	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING

0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult



Please specify if you have experienced any of the following:

	# total injuries	# total surgeries	Did the injury end your pro career?		Any current limitations from the injury?	
			Yes	No	Yes	No
Neck fracture/spinal cord injury			Yes	No	Yes	No
Disc rupture/herniation			Yes	No	Yes	No
Shoulder dislocation			Yes	No	Yes	No
Biceps/triceps tear			Yes	No	Yes	No
Elbow dislocation/separation			Yes	No	Yes	No
Arm/wrist/hand fracture			Yes	No	Yes	No
Hip dislocation/fracture			Yes	No	Yes	No
Thigh/leg fracture			Yes	No	Yes	No
Hamstring/Quad tear			Yes	No	Yes	No
Knee/Patellar dislocation			Yes	No	Yes	No
MCL tear			Yes	No	Yes	No
LCL tear			Yes	No	Yes	No
ACL tear			Yes	No	Yes	No
PCL tear			Yes	No	Yes	No
Meniscus tear			Yes	No	Yes	No
Calf/achilles tendon tear			Yes	No	Yes	No
Ankle ligament tear			Yes	No	Yes	No
Ankle/foot fracture			Yes	No	Yes	No
Other:			Yes	No	Yes	No

Please describe any limitations noted above



Chronic Pain Grade Scale

Pain intensity items

1. How would you rate your back/headache/facial pain on a 0-10 scale at the present time. That is right now. Where 0 is 'no pain' and 10 is 'pain as bad as could be'?

No pain											Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10	

2. In the past 6 months, how intense was your worst pain rated on a 0-10 scale where 0 is 'no pain' and 10 is 'pain as bad as could be'?"

No pain											Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10	

3. In the past 6 months, on the average, how intense was your pain rated on a 0-10 scale where 0 is 'no pain' and 10 is 'pain as bad as could be'?" (That is, your usual pain at times you were experiencing pain.)

No pain											Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10	

Disability items

4. About how many days in the last 6 months have you been kept from your usual activities (work, school or housework) because of back/headache/ facial pain? Disability days _____

5. In the past 6 months, how much has back/headache/facial pain interfered with your daily activities rated on a 0-10 scale where 0 is 'no interference' and 10 is 'unable to carry on any activities'?

No interference											Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10	

6. In the past 6 months, how much has back/headache/facial pain changed your ability to take part in recreational, social and family activities where 0 is 'no change' and 10 is 'extreme change'?"

No change											Extreme change
0	1	2	3	4	5	6	7	8	9	10	

7. In the past 6 months, how much has back/headache/facial pain changed your ability to work (including housework) where 0 is 'no change' and 10 is 'extreme change'?"

No change											Extreme change
0	1	2	3	4	5	6	7	8	9	10	



SUMMARY OF HEAD IMPACTS

- Provide the following about any head trauma, diagnosed/suspected concussions, etc that you have had.
- How many concussions/head injuries do you think that you have had? Total: _____
- Have you ever lost consciousness? No Yes, If yes, how many times _____
- Have you ever had any medical care for any diagnosed/suspected concussion, or other head injury? No Yes
- Have you ever had trouble remembering things or feel confused after a suspected or diagnosed concussion/head injury? No Yes
- Have you ever missed any practice or playing time due to a suspected or diagnosed concussion/head injury? No Yes
- What was the longest time that you had symptoms after a suspected or diagnosed concussion/head injury? No Yes

Please use the space below to provide as much information as you can remember about any specific head injuries. If necessary, use other sheets and bring them to your visit.

	Date	Loss of Consciousness	Missed practice or playing time	Length of symptoms (Days, weeks, etc)	Treatment
1		No Yes	No Yes		No Yes
2		No Yes	No Yes		No Yes
3		No Yes	No Yes		No Yes
4		No Yes	No Yes		No Yes
5		No Yes	No Yes		No Yes
6		No Yes	No Yes		No Yes
7		No Yes	No Yes		No Yes
8		No Yes	No Yes		No Yes
9		No Yes	No Yes		No Yes
10		No Yes	No Yes		No Yes



Impact #1

Timeframe (Circle One): Professional Armed Services College High School Pre-High School

Sport: _____ Date or Season: _____

Setting: Game / Practice / Other: _____ Position: _____

Impact Involved (Circle One): Head to Opponents Head Head to Field Other: _____

Location of Head Impact (Circle One): Front Back Left Right Top

LOC: No Yes Duration(number of plays or time) _____

Amnesia: No Yes Duration(number of plays or time) _____

Confusion No Yes Duration(number of plays or time) _____

Sidelined No Yes Duration(number of plays or time) _____

Returned to Play No Yes If yes, Duration (number of plays or time) _____

How long did your symptoms last (Weeks, days, hours, etc): _____

How long were you held out of physical activity? (Weeks, days, etc): _____

Additional Information:

Impact #2

Timeframe (Circle One): Professional Armed Services College High School Pre-High School

Sport: _____ Date or Season: _____

Setting: Game / Practice / Other: _____ Position: _____

Impact Involved (Circle One): Head to Opponents Head Head to Field Other: _____

Location of Head Impact (Circle One): Front Back Left Right Top

LOC: No Yes Duration(number of plays or time) _____

Amnesia: No Yes Duration(number of plays or time) _____

Confusion No Yes Duration(number of plays or time) _____

Sidelined No Yes Duration(number of plays or time) _____

Returned to Play No Yes If yes, Duration (number of plays or time) _____

How long did your symptoms last (Weeks, days, hours, etc): _____

How long were you held out of physical activity? (Weeks, days, etc): _____

Additional Information:



Impact #3

Timeframe (Circle One): Professional Armed Services College High School Pre-High School

Sport: _____ Date or Season: _____

Setting: Game / Practice / Other: _____ Position: _____

Impact Involved (Circle One): Head to Opponents Head Head to Field Other: _____

Location of Head Impact (Circle One): Front Back Left Right Top

LOC: No Yes Duration(number of plays or time) _____

Amnesia: No Yes Duration(number of plays or time) _____

Confusion No Yes Duration (number of plays or time) _____

Sidelined No Yes Duration(number of plays or time)_____

Returned to Play No Yes If yes, Duration (number of plays or time)_____

How long did your symptoms last (Weeks, days, hours, etc): _____

How long were you held out of physical activity? (Weeks, days, etc): _____

Additional Information:

Impact #4

Timeframe (Circle One): Professional Armed Services College High School Pre-High School

Sport: _____ Date or Season: _____

Setting: Game / Practice / Other: _____ Position: _____

Impact Involved (Circle One): Head to Opponents Head Head to Field Other: _____

Location of Head Impact (Circle One): Front Back Left Right Top

LOC: No Yes Duration (number of plays or time) _____

Amnesia: No Yes Duration(number of plays or time) _____

Confusion No Yes Duration(number of plays or time) _____

Sidelined No Yes Duration(number of plays or time)_____

Returned to Play No Yes If yes, Duration (number of plays or time)_____

How long did your symptoms last (Weeks, days, hours, etc): _____

How long were you held out of physical activity? (Weeks, days, etc): _____

Additional Information:



Impact #5

Timeframe (Circle One): Professional Armed Services College High School Pre-High School

Sport: _____ Date or Season: _____

Setting: Game / Practice / Other: _____ Position: _____

Impact Involved (Circle One): Head to Opponents Head Head to Field Other: _____

Location of Head Impact (Circle One): Front Back Left Right Top

LOC: No Yes Duration(number of plays or time) _____

Amnesia: No Yes Duration(number of plays or time) _____

Confusion No Yes Duration(number of plays or time) _____

Sidelined No Yes Duration(number of plays or time) _____

Returned to Play No Yes If yes, Duration (number of plays or time) _____

How long did your symptoms last (Weeks, days, hours, etc): _____

How long were you held out of physical activity? (Weeks, days, etc): _____

Additional Information:

Impact #6

Timeframe (Circle One): Professional Armed Services College High School Pre-High School

Sport: _____ Date or Season: _____

Setting: Game / Practice / Other: _____ Position: _____

Impact Involved (Circle One): Head to Opponents Head Head to Field Other: _____

Location of Head Impact (Circle One): Front Back Left Right Top

LOC: No Yes Duration(number of plays or time) _____

Amnesia: No Yes Duration(number of plays or time) _____

Confusion No Yes Duration(number of plays or time) _____

Sidelined No Yes Duration(number of plays or time) _____

Returned to Play No Yes If yes, Duration (number of plays or time) _____

How long did your symptoms last (Weeks, days, hours, etc): _____

How long were you held out of physical activity? (Weeks, days, etc): _____

Additional Information:



During your athletic participation did you have any spinal impacts or injuries? No Yes

If yes, estimated total # _____

Please provide the following information about your spine injuries:

Spine Impact #1: Date or season: _____

Describe event and consequences:

Location	Neck	Upper Back	Low back
Numbness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Duration (number of plays or time)_____
Weakness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Duration (number of plays or time)_____
Sidelined	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Duration (number of plays or time)_____
Returned to Play	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Duration (number of plays or time)_____

Spine Impact #2: Date or season: _____

Describe event and consequences:

Location	Neck	Upper Back	Low back
Numbness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Duration (number of plays or time)_____
Weakness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Duration (number of plays or time)_____
Sidelined	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Duration (number of plays or time)_____
Returned to Play	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Duration (number of plays or time)_____



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Outside of athletic participation, have you ever had any spinal impacts or injuries? No Yes

If no, skip this page and continue to next page.

If yes, please describe the event(s)

If yes, which of these symptoms occurred on a scale of 0-10 (0 being did not occur, 10 being the highest intensity):

Type of Symptom	1st Spinal Injury	2nd Spinal Injury	3rd Spinal Injury
Chest pressure or dull pain			
Neck pressure or dull pain			
Back pressure or dull pain			
Head pressure or dull pain			
Intense stinging sensation or sharp pain			
Sharp head pains or migraines			
Exaggerated reflex activities or spasms			
Loss of Movement			
Weakness, incoordination or paralysis in any part of your body			
Loss of sensation, including the ability to feel heat, cold, and touch in areas other than your extremities			
Numbness, tingling, or loss of sensation in your hands, fingers, feet, or toes			
Difficulty with balance and walking			
Impaired breathing			
Oddly positioned or twisted neck or back			
Loss of bowel or bladder control			
Changes in sexual function, sexual sensitivity, or fertility			
Other:			



Present Signs & Symptoms:

Graded Symptom Checklist: Rate each of the following based on how you feel now

0 = not experiencing symptom 1 = very minor 2 = annoyingly present 3 = moderate level
4 = more significant 5 = intense and disruptive 6 = worst and unbearable.

GSCL	None	Mild	Mild	Moderate	Moderate	Severe	Severe
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
Trouble falling asleep	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Fatigue or low energy	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 or attention	0	1	2	3	4	5	6
Difficulty remembering or memory Loss	0	1	2	3	4	5	6
Confusion	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 or Depression	0	1	2	3	4	5	6
Nervous or anxious	0	1	2	3	4	5	6

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Number of Symptoms: ____/22

Symptom Severity Score: ____/132

Do any of the above symptoms get worse with physical activity?

Yes No

Do any of the above symptoms get worse with mental activity?

Yes No



General Somatic:	None	Mild	Mild	Moderate	Moderate	Severe	Severe
Pain in other parts of body: _____	0	1	2	3	4	5	6
Problems with sleeping	0	1	2	3	4	5	6
Primary Neurological Symptoms:							
Gait or balance problems	0	1	2	3	4	5	6
Vision loss or change	0	1	2	3	4	5	6
Hearing loss or change	0	1	2	3	4	5	6
Loss of smell or taste	0	1	2	3	4	5	6
Speech changes	0	1	2	3	4	5	6
Weakness	0	1	2	3	4	5	6
Tremors: postural, resting, intentional	0	1	2	3	4	5	6
Bowel or bladder disturbances	0	1	2	3	4	5	6
Sexual dysfunction	0	1	2	3	4	5	6
Neurobehavioral/Cognitive Problems							
Difficulty planning and organizing	0	1	2	3	4	5	6
Difficulty anticipating consequences	0	1	2	3	4	5	6
Word finding difficulties	0	1	2	3	4	5	6
Difficulty understanding verbal conversations	0	1	2	3	4	5	6
Lost in a familiar environment	0	1	2	3	4	5	6
Loss of appetite	0	1	2	3	4	5	6
Suicidal or homicidal thoughts	0	1	2	3	4	5	6
Verbally and/or physically aggressive	0	1	2	3	4	5	6
Personality changes	0	1	2	3	4	5	6
Dis-inhibition/speaking out of turn	0	1	2	3	4	5	6
Avoidance of social and/or work events	0	1	2	3	4	5	6
Intrusive distressing thoughts	0	1	2	3	4	5	6
Repetitive motor activity	0	1	2	3	4	5	6

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Number of Symptoms: ____/24

Symptom Severity Score: ____/144

Do any of the above symptoms get worse with physical activity?

Yes No

Do any of the above symptoms get worse with mental activity?

Yes No



HISTORY OF PERSISTENT NEUROBEHAVIORAL SYMPTOMS:

General Somatic

Headache No Yes

Onset _____

Location: _____

Frequency: _____

Severity: _____

Quality (e.g., throb): _____

Timing: _____

Duration: _____

Triggers: _____

Associated symptoms (e.g., photophobia, sonophobia, nausea, vomiting, neurologic symptoms):

Relieved by: _____

How many days per month do you miss work due to headache? 0 1-3 4-6 7-9 >10

How many days per month do you miss social or family events? 0 1-3 4-6 7-9 >10

Sleep Disturbance: No Yes, if yes, please respond to items below:

Difficulty falling asleep: No Yes: Severity: ___/10; How often: _____; Better Same Worse

Difficulty staying asleep: No Yes: Severity: ___/10; How often: _____; Better Same Worse

Nightmares: No Yes: Severity: ___/10; How often: _____; Better Same Worse

Acts out dreams: No Yes: Severity: ___/10; How often: _____; Better Same Worse

Early morning wakening: No Yes: Severity: ___/10; How often: _____; Better Same Worse

Daytime drowsiness: No Yes: Severity: ___/10; How often: _____; Better Same Worse

Naps: No Yes; How many: _____/Day;



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Pain in Other Parts of the Body

Site of pain	Date of onset	Severity (1-10)	Frequency Times /day or week	Duration	Triggers	Relieved by	Progression since onset
Neck							Better Same Worse
							Better Same Worse
							Better Same Worse
							Better Same Worse
							Better Same Worse
							Better Same Worse



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Chronic Pain Assessment

http://www.endo.com/File%20Library/Products/Other/Brief_Pain_Inventory.pdf



http://www.centreforsleep.com/assets/images/pdf/insomnia_assessment_guideline07.pdf



– INFORMANT INTAKE FORM –

All responses are considered confidential health information. This information will only be used by our medical team in the development of a plan for the related patient's upcoming evaluation at Tulane Institute of Sports Medicine.

****THIS FORM SHOULD BE COMPLETED BY SPOUSE OR CLOSE RELATIVE****

Informant's Name: _____ **Date:** _____

Relationship to Participant: _____

Participant's Name: _____

COGNITIVE FUNCTION-INFORMANT

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, A change	No, No change	N/A I don't know
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. Daily problems with thinking and/or memory			
TOTAL AD8 SCORE			

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COGNITIVE FUNCTION-INFORMANT

The assessment

Now we want you to remember what your friend or relative was like 10 years ago and to compare it with what he/she is like now. 10 years ago was 20___. On this page there are situations where this person has to use his/her memory or intelligence and we want you to indicate whether this has improved, stayed the same or got worse than in that situation over the past 10 years.

Note the importance of comparing his/her present performance with 10 years ago. So if 10 years ago this person always forgot where he/she had left things and he/she still does this, then this would be considered 'Not much change'. Please indicate the changes you have observed by circling the appropriate answer.

		1	2	3	4	5
1	Remembering things about family and friends, eg occupations, birthdays, addresses	Much improved	A bit improved	Not much change	A bit worse	Much worse
2	Remembering things that have happened recently	Much improved	A bit improved	Not much change	A bit worse	Much worse
3	Recalling conversations a few days later	Much improved	A bit improved	Not much change	A bit worse	Much worse
4	Remembering her/his address and telephone number	Much improved	A bit improved	Not much change	A bit worse	Much worse
5	Remembering what day and month it is	Much improved	A bit improved	Not much change	A bit worse	Much worse
6	Remembering where things are usually kept	Much improved	A bit improved	Not much change	A bit worse	Much worse
7	Remembering where to find things which have been put in a different place from usual	Much improved	A bit improved	Not much change	A bit worse	Much worse
8	Knowing how to work familiar machines around the house	Much improved	A bit improved	Not much change	A bit worse	Much worse
9	Learning to use a new gadget or machine around the house	Much improved	A bit improved	Not much change	A bit worse	Much worse
10	Learning new things in general	Much improved	A bit improved	Not much change	A bit worse	Much worse
11	Following a story in a book or on TV	Much improved	A bit improved	Not much change	A bit worse	Much worse
12	Making decisions on everyday matters	Much improved	A bit improved	Not much change	A bit worse	Much worse
13	Handling money for shopping	Much improved	A bit improved	Not much change	A bit worse	Much worse
14	Handling financial matters, eg the pension, dealing with the bank	Much improved	A bit improved	Not much change	A bit worse	Much worse
15	Handling other everyday arithmetic problems, eg knowing how much food to buy, knowing how long between visits from family or friends	Much improved	A bit improved	Not much change	A bit worse	Much worse
16	Using his/her intelligence to understand what's going on and to reason things through	Much improved	A bit improved	Not much change	A bit worse	Much worse



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Cognitive Symptoms Checklist:

Regarding the person being evaluated, circle YES for each symptom that is present and represents a CHANGE from a previous level of functioning.

Then circle the number (1 = Mild, 2 = Moderate, 3 = Severe) to describe its severity.

If the symptom is NOT present or is not a change for them, circle NO.

1. Does he repeat saying things as if they forgot?	YES	NO	1	2	3
2. Does he forget about past or upcoming events?	YES	NO	1	2	3
3. Does he get lost in familiar places?	YES	NO	1	2	3
4. Is he less interested in family or social activities?	YES	NO	1	2	3
5. Is he less interested in hobbies or leisure activities?	YES	NO	1	2	3
6. Does he have difficulty finding words or expressing thoughts?	YES	NO	1	2	3
7. Does he have difficulty understanding what he reads or hears?	YES	NO	1	2	3
8. Does he have difficulty managing a checkbook or personal finances?	YES	NO	1	2	3
9. Does he have difficulty making plans or being organized?	YES	NO	1	2	3
10. Does he have difficulty making decisions?	YES	NO	1	2	3
11. Does he have impaired judgment?	YES	NO	1	2	3
12. Does he have impaired insight into his own limitations?	YES	NO	1	2	3

Neuropsychiatric Inventory – Questionnaire:

Instructions: Please answer the following questions based on **CHANGES** that have occurred since the patient first began to experience memory problems. Circle “Yes” if the symptom has been present **IN THE LAST MONTH**. Otherwise, circle “No”. For each item marked “Yes”:

A. Rate the **SEVERITY** for the symptom (how it affects the patient):

- 1 = **MILD** (noticeable, but not a significant change)
- 2 = **MODERATE** (significant, but not a dramatic change)
- 3 = **SEVERE** (very marked or prominent, a dramatic change)

B. Rate the **DISTRESS** you experience due to the symptom (how it affects you):

- 0 = **NOT DISTRESSING AT ALL**
- 1 = **MINIMAL** (slightly distressing, not a problem to cope with)
- 2 = **MILD** (not very distressing, generally easy to cope with)
- 3 = **MODERATE** (fairly distressing, not always easy to cope with)
- 4 = **SEVERE** (very distressing, difficult to cope with)
- 5 = **EXTREME OR VERY SEVERE** (extremely distressing, unable to cope with)

Please answer each question carefully and give specific details about the behavior.

DELUSIONS

Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?

Yes No

SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

HALLUCINATIONS

Does the patient have hallucinations such as false visions or voices? Does he/she seem to hear or see things that are not present?

Yes No

SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

AGITATION/AGGRESSION

Is the patient resistive to help from others at times, or hard to handle?

Yes No

SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

DEPRESSION/DYSPHORIA

Does the patient seem sad or say the he/she is depressed?

Yes No

SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

ANXIETY

Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, unable to relax, or feeling excessively tense?

Yes No

SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5



- SEVERITY:** 1 = **MILD** (noticeable, but not a significant change)
 2 = **MODERATE** (significant, but not a dramatic change)
 3 = **SEVERE** (very marked or prominent, a dramatic change)
- DISTRESS:** 0 = **NOT DISTRESSING AT ALL**
 1 = **MINIMAL** (slightly distressing, not a problem to cope with)
 2 = **MILD** (not very distressing, generally easy to cope with)
 3 = **MODERATE** (fairly distressing, not always easy to cope with)
 4 = **SEVERE** (very distressing, difficult to cope with)
 5 = **EXTREME OR VERY SEVERE** (extremely distressing, unable to cope with)

FRUSTRATION	Does the patient appear to have decreased frustration tolerance level?
Yes No	SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5
ELATION/EUPHORIA	Does the patient appear to feel too good or act excessively happy?
Yes No	SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5
APATHY/INDIFFERENCE	Does the patient seem less interested in his/her usual activities or in the activities and plans of others?
Yes No	SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5
DISINHIBITION	Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them, or saying things that may hurt people's feelings?
Yes No	SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5
IRRITABILITY/LABILITY	Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?
Yes No	SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5
MOTOR DISTURBANCE	Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?
Yes No	SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5
NIGHTTIME BEHAVIORS	Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?
Yes No	SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5
	Has the patient lost or gained weight, or had a change in the type of food that he/she likes?
	SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5



Review of Symptoms: Please check the items below that you currently have or have experienced recently.

<p>CONSTITUTIONAL SYMPTOMS</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Good general health lately <input type="checkbox"/> Unexplained weight loss or gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Fever or chills <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Night sweats
<p>EYES / VISION</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Glasses or contacts <input type="checkbox"/> Pain <input type="checkbox"/> Redness <input type="checkbox"/> Blurry or double vision <input type="checkbox"/> Flashing lights <input type="checkbox"/> Specks <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Eye irritation <input type="checkbox"/> Drainage from eyes <input type="checkbox"/> Last eye exam- Date: _____
<p>EARS NOSE MOUTH & THROAT</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Ringing in ears (tinnitus) <input type="checkbox"/> Earache <input type="checkbox"/> Drainage from ears <input type="checkbox"/> Last hearing test- Date: _____ <input type="checkbox"/> Nasal stuffiness <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Nasal itching <input type="checkbox"/> Hay fever <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus pain <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Dentures <input type="checkbox"/> Sore tongue <input type="checkbox"/> Dry mouth <input type="checkbox"/> Bad breath or bad taste in mouth <input type="checkbox"/> Voice change <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore throat <input type="checkbox"/> Non-healing sores <input type="checkbox"/> Last dental exam- Date: _____
<p>CARDIOVASCULAR SYSTEM</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Chest pain or discomfort <input type="checkbox"/> Tightness in chest <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of breath with activity (dyspnea) <input type="checkbox"/> Difficulty breathing lying down (orthopnea) <input type="checkbox"/> Swelling (edema) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)
<p>RESPIRATORY SYSTEM</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Cough (dry or wet, productive)



	<ul style="list-style-type: none"><input type="checkbox"/> Sputum (color and amount): _____<input type="checkbox"/> Coughing up blood (hemoptysis)<input type="checkbox"/> Shortness of breath (dyspnea)<input type="checkbox"/> Wheezing<input type="checkbox"/> Asthma<input type="checkbox"/> Painful breathing
GASTROINTESTINAL SYSTEM	<ul style="list-style-type: none"><input type="checkbox"/> Swallowing difficulties<input type="checkbox"/> Heartburn<input type="checkbox"/> Frequent heartburn<input type="checkbox"/> Change in appetite<input type="checkbox"/> Loss of appetite<input type="checkbox"/> Nausea<input type="checkbox"/> Change in bowel habits<input type="checkbox"/> Rectal bleeding<input type="checkbox"/> Blood in stool<input type="checkbox"/> Constipation<input type="checkbox"/> Diarrhea<input type="checkbox"/> Yellow eyes or skin (jaundice)<input type="checkbox"/> Peptic ulcer (stomach or duodenal)
MUSCULOSKELETAL SYSTEM	<ul style="list-style-type: none"><input type="checkbox"/> Leg cramps<input type="checkbox"/> Muscle aches<input type="checkbox"/> Stiffness<input type="checkbox"/> Redness of joints<input type="checkbox"/> Swelling of joints<input type="checkbox"/> Neck pain<input type="checkbox"/> Neck stiffness<input type="checkbox"/> Cold extremities (hands or feet)<input type="checkbox"/> Difficulty walking
PSYCHIATRIC HEALTH	<ul style="list-style-type: none"><input type="checkbox"/> Confusion<input type="checkbox"/> Difficulty concentrating<input type="checkbox"/> Nervousness<input type="checkbox"/> Depression<input type="checkbox"/> Memory loss<input type="checkbox"/> High stress<input type="checkbox"/> Mood swings<input type="checkbox"/> Suicidal ideation<input type="checkbox"/> Obsessive-compulsive tendencies
NEUROLOGICAL SYSTEM	<ul style="list-style-type: none"><input type="checkbox"/> Tingling/numbness<input type="checkbox"/> Focal weakness<input type="checkbox"/> Dizziness<input type="checkbox"/> Fainting<input type="checkbox"/> Seizures<input type="checkbox"/> Tremors or shaking<input type="checkbox"/> Paralysis<input type="checkbox"/> Stroke<input type="checkbox"/> Poor balance<input type="checkbox"/> Headache
GENITOURINARY SYSTEM	<ul style="list-style-type: none"><input type="checkbox"/> Kidney stones<input type="checkbox"/> Testicle pain or swelling<input type="checkbox"/> Pain with sex<input type="checkbox"/> Hernia<input type="checkbox"/> Penile discharge



	<ul style="list-style-type: none"><input type="checkbox"/> Sores<input type="checkbox"/> Masses or pain<input type="checkbox"/> Erectile dysfunction<input type="checkbox"/> Sexually transmitted diseases: _____<input type="checkbox"/> Frequent urination<input type="checkbox"/> Urgent urination<input type="checkbox"/> Burning or pain during urination<input type="checkbox"/> Blood in urine (hematuria)<input type="checkbox"/> Incontinence<input type="checkbox"/> Change in urinary strength
INTEGUMENTARY SYSTEM (skin, hair, nails) & BREAST HEALTH	<ul style="list-style-type: none"><input type="checkbox"/> Rashes<input type="checkbox"/> Lumps<input type="checkbox"/> Itching<input type="checkbox"/> Dryness<input type="checkbox"/> Color changes<input type="checkbox"/> Hair and nail changes<input type="checkbox"/> Boils or blisters<input type="checkbox"/> Skin lesions or moles<input type="checkbox"/> Photosensitivity<input type="checkbox"/> Hives<input type="checkbox"/> Hair loss
ENDOCRINE SYSTEM	<ul style="list-style-type: none"><input type="checkbox"/> Thyroid disease<input type="checkbox"/> Diabetes (<input type="checkbox"/> insulin or <input type="checkbox"/> non-insulin) check one<input type="checkbox"/> Heat intolerance<input type="checkbox"/> Cold intolerance<input type="checkbox"/> Sweating<input type="checkbox"/> Frequent urination (polyuria)<input type="checkbox"/> Thirst (polydypsia)<input type="checkbox"/> Change in appetite (polyphagia)
HEMATOLOGIC & LYMPHATIC SYSTEMS	<ul style="list-style-type: none"><input type="checkbox"/> Neck lumps<input type="checkbox"/> Swollen glands<input type="checkbox"/> Slow to heal after cuts<input type="checkbox"/> Anemia<input type="checkbox"/> Phlebitis (inflammation of veins) in legs or arms<input type="checkbox"/> Varicose (enlarged or twisted) veins in legs<input type="checkbox"/> Past blood transfusions<input type="checkbox"/> Calf pain with walking<input type="checkbox"/> Leg cramping<input type="checkbox"/> Ease of bruising<input type="checkbox"/> Ease of bleeding
ALLERGIES	<ul style="list-style-type: none"><input type="checkbox"/> Ear fullness<input type="checkbox"/> Runny nose

