



## **PLEASE READ BEFORE YOUR BASELINE TEST APPOINTMENT**

In order to bring you the highest standard of concussion care, *Impact Physiotherapy* provides a full-service concussion testing and rehabilitative program. A vital component of concussion management involves obtaining a pre-season or “baseline” test. Baseline testing is essential for athletes at risk of concussive injury as it provides an important point of reference when managing head injury and determining readiness to return-to-play. We thank you for taking a proactive approach to concussion management and participating in our baseline program.

Our testers administer a **supervised ImPACT® assessment** (computerized neurocognitive test). ImPACT® is the most widely used and scientifically validated concussion assessment tool available ([www.impacttest.com](http://www.impacttest.com)). The program measures multiple aspects of cognitive functioning in athletes, including:

- ✓ Attention span
- ✓ Working memory
- ✓ Sustained and selective attention time
- ✓ Response variability
- ✓ Non-verbal problem solving
- ✓ Reaction time

Should you sustain a concussion during the sporting season, please contact us 519-843-3961 as early as possible to book a follow-up assessment. Our healthcare professionals are highly trained in the assessment and rehabilitation of these types of injuries and will work collaboratively with the GP, Pediatrician or Sport Physician involved in your medical care.

We require a completed consent form prior to test administration. If you have been given the consent form in advance, please fill it out and bring it on testing day or forward it to us ahead of time. If you have not been given a consent form one will be provided to you at your appointment. In order to ensure a smooth testing process, we ask that you **ARRIVE 15 MINUTES IN ADVANCE OF YOUR APPOINTMENT.**

## TIPS FOR SUCCESSFUL TEST TAKING

- Be sure to listen to all instructions carefully during the computer-based testing portion and give it your **best effort**. This will lessen the chance of you having to retake the test due to a less-than-optimal result.
- If during the test you find you do not understand the instructions, or if your computer freezes/test is interrupted, notify one of the test instructors right away.
- Let us know if you are sleepy, fatigued, rushed, distracted, emotionally distressed, or if you have been under the influence of intoxicants within the last 24 hours. We will reschedule your test for a day that you are feeling better.
- If you are testing with your teammates, please be courteous of those test takers around you and concentrate on your own computer
- **If you normally wear contact lenses or glasses on a full time basis, or if you have glasses specifically for reading, be sure to bring them to the test**
- Give each task your **BEST EFFORT**

### A note on **Neurocognitive Testing**:

On rare occasions, we do not obtain a successful result on the first test. Many computerized cognitive assessment tools have built-in “quality control checks” so that if performance is less than optimal or an athlete is intentionally trying to do poorly, the program will notify us. In these situations, we will ask you to complete a second test or have you return on a later date, as we do not want to *underestimate* your performance level.

Often invalid attempts are a result of the testing environment (distraction by teammates, noise, etc.) or internal factors (lack of motivation, fatigue, frustration, or failure to understand the test principles). It is important to us that we obtain an accurate baseline, and for some, this requires repeat testing or a change in environment.

If you have any questions regarding the baseline process or concussion management in general, please do not hesitate to contact us!

**Impact Physiotherapy & Performance Team**

519-843-3961



Athlete Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (dd/mm/yy)  
 Age: \_\_\_\_\_ Parent Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Team Name (if applicable): \_\_\_\_\_

**CONFIDENTIAL MEDICAL INFORMATION AND CONCUSSION HISTORY**

**Please complete the following questions as fully and carefully as possible in order to help us effectively interpret the results of your baseline assessment. This information will remain strictly confidential.**

Concussion History: include month/year, how it happened, symptoms experienced, and length of recovery:

No known concussions

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do any of the following conditions apply? (please indicate)

- ADD/ADHD    Clinical Depression/Anxiety    Migraine Headaches    Learning Disability    Sleep Disorder
- Dyslexia    Repeated one or more grade levels    Received speech therapy
- Individual Education Plan (IEP)    Motion Sickness / Car Sickness    Visual Condition: \_\_\_\_\_

Please indicate your level of academic performance:

- Below average (C/D Student)    Average (B/C Student)    Above Average (A/B Student)

PLEASE REVIEW BELOW, SIGN, AND RETURN

**I hereby consent to the administration and supervision of a concussion baseline test by *Impact Physiotherapy & Performance*.** I understand that baseline testing does not prevent concussive injuries, but allows healthcare professionals to better manage the injury should it occur.

\_\_\_\_\_  
 SIGNED

\_\_\_\_\_  
 PRINT NAME

\_\_\_\_\_  
 DATE

Please Indicate and rate if you experience any of the following symptoms:

**0 = NONE; 1-2 = Mild; 3-4 = Moderate; 5-6 = Severe**

|                          |               |                          |               |
|--------------------------|---------------|--------------------------|---------------|
| Headache                 | 0 1 2 3 4 5 6 | Sensitivity to Noise     | 0 1 2 3 4 5 6 |
| Nausea                   | 0 1 2 3 4 5 6 | Irritability             | 0 1 2 3 4 5 6 |
| Vomiting                 | 0 1 2 3 4 5 6 | Sadness                  | 0 1 2 3 4 5 6 |
| Balance Problems         | 0 1 2 3 4 5 6 | Nervousness              | 0 1 2 3 4 5 6 |
| Dizziness                | 0 1 2 3 4 5 6 | Feeling more Emotional   | 0 1 2 3 4 5 6 |
| Fatigue                  | 0 1 2 3 4 5 6 | Numbness or Tingling     | 0 1 2 3 4 5 6 |
| Trouble Falling Asleep   | 0 1 2 3 4 5 6 | Feeling Slowed Down      | 0 1 2 3 4 5 6 |
| Sleeping more than Usual | 0 1 2 3 4 5 6 | Feeling Mentally "Foggy" | 0 1 2 3 4 5 6 |
| Sleeping less than Usual | 0 1 2 3 4 5 6 | Difficulty Concentrating | 0 1 2 3 4 5 6 |
| Drowsiness               | 0 1 2 3 4 5 6 | Difficulty Remembering   | 0 1 2 3 4 5 6 |
| Sensitivity to Light     | 0 1 2 3 4 5 6 | Visual Problems          | 0 1 2 3 4 5 6 |