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). 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

In addition to ImPACT® testing, *Impact Physiotherapy* recommends baseline assessment of both balance and visual coordination, as these skills are often impaired following a concussion. (Please note that our baseline visual screen in no way replaces the routine eye care provided by your regular eye doctor).

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. Please be aware that for the comprehensive testing, you may be here for 2 hours.**

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: ________________________
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

Symptom	Rating	Symptom	Rating
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

Name:	Family Physician/ Location: DR.	Date of Birth: (M/D/YR)
Mailing Address / Postal Code:		
Home Telephone Number:	Cell Phone Number:	
Email:		

Who referred you? **Referral Date: (M/D/YR)____________**

- Doctor (Provide name)
- Friend/ Family Member(Provide name)

Where did you get our phone number?

- Phone Book
- Referral pad
- Other :____
- Business Card
- Internet

CONSENT:
I hereby consent to the assessment by the Physiotherapy staff of Impact Physiotherapy & Performance.

Date: _________________ Signature: ____________________ Witness: __________________

I hereby consent to the Plan of Care as explained by the Physiotherapist.
I understand the possible risks and benefits of this treatment and that any changes to this plan of care will be discussed with me.
I also understand that this clinic uses support personnel (trained Physiotherapy Assistants) to assist in carrying out some aspects of treatment but this is always done under the direction of the Physiotherapist.
It is my right to withdraw my consent to treatment at any time.

Date: _________________ Signature: ____________________ Witness: _______________

PRE-ASSESSMENT QUESTIONNAIRE

1. Do you ***or have you had*** any of the following problems?

A) Heart Disease	B) High/Low blood Pressure
C) Lung Disease	D) Diabetes
E) Epilepsy	F) Arthritis
G) Tumor/cancer	H) HIV/AIDS
I) Hepatitis A, B, C	J) Osteoporosis/Osteopenia

2. Do you smoke? Y N If yes, how many packs/day _________________________

3. Do you have vision or hearing impairments? _________________________________

4. Do you have a pacemaker or metal implant? _________________________

5. Are you or do you suspect you are pregnant? _________________________

6. Have you had any surgery in the past? Please list: _________________________

7. Do you have any allergies? Are you allergic to latex? _________________________

8. Do you take any medications (please list. If you are taking a large list of medications, you can provide a copy of the list from your pharmacy)? _________________________

____

Date: _______________________ Signature of Client: __________________

Client Information and Consent Form

Impact Physiotherapy is a fee-for-service physiotherapy clinic. A client can access this option through extended health benefits or personal payment.

It is our policy that accounts are paid on the date of your appointment. Invoices will be provided after each visit for submission to:

- Extended Health Insurance Plan
- Deductible Medical Expenses

Cash, personal cheque, Visa, MasterCard and debit will be accepted for payment of accounts.

Please provide us with the following information of your extended health benefit coverage (if applicable):

Name of Ins. Company ____________________ Policy/Plan #_________________________

ID#:___________________________________ Dollar Limit:__________________________

Percentage coverage:_____________________ Who is the policy holder?______________________

If you are uncertain of the above information, please contact your Health benefit company. Unfortunately due to the confidentiality act, we are unable to do it on your behalf.

Notice to insured extended health clients:

If you receive a payment cheque from your company **in your name**, we unfortunately cannot accept your company cheque for payment towards your physiotherapy treatments. Our financial institution will not accept third party cheques. The payee on the cheque must be **Impact Physiotherapy &Performance Inc.** **This means you are responsible for payment of your physiotherapy services.**

Cancellation Policy:

You will be billed for missed appointments unless 24 hours advanced notice of cancellation is received. In the event that cancellation is not received in a timely fashion, a fee of $20 will be charged to your account.

I hereby agree that I will pay for any missed or cancelled appointments at a fee of $20/incident should they occur.

I hereby agree that I will pay for all services rendered to me by Impact Physiotherapy.

I have read and understood all of the above statements and agree to adhere to them accordingly. I give consent to be assessed by the staff at Impact Physiotherapy.

Client's Name (Print): ___________________ Client's Signature: __________________

Date: ___________________ Witness: ______________________