PLEASE READ BEFORE YOUR NEUROCOGNITIVE TEST APPOINTMENT

In order to bring you the highest standard of concussion care, *Impact Physiotherapy & Performance* provides a full-service concussion testing and rehabilitative 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 individuals, 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 & Performance* recommends a thorough assessment of both balance and visual coordination, as these skills are often impaired following a concussion. (Please note that our visual screen in no way replaces the routine eye care provided by your regular eye doctor).

We require a completed consent form prior to test administration. Please have this consent form along with the other forms you have been emailed prior to your appointment. **Please be aware that for the initial appointment, 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 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 test, and for some, this requires repeat testing or a change in environment.

If you have any questions regarding the 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

Confidential Patient Information Form

Please complete the following questionnaire as fully and carefully as possible. Your answers will help us to process your file, determine the nature of your injury, and decide how best to assist you. This information will remain strictly confidential.

PERSONAL INFORMATION

Name:_____ Date of Birth: ____/____/_____ (dd/mm/yyyy) Age:_____ M/F

Address:_____ City:_____ Postal Code: _____

Telephone: (home) _____ (work and/or cell) _____

Email: _____

Emergency Contact: (name/relation) _____ (Tel) _____

Current Occupation: _____

Name of Medical Doctor: _____ (Tel) _____

If Sport Related Injury:

Sport:_____ Team: _____

How were you referred to the Shift Concussion Management Program?_____

INJURY/DESCRIPTION OF COMPLAINT

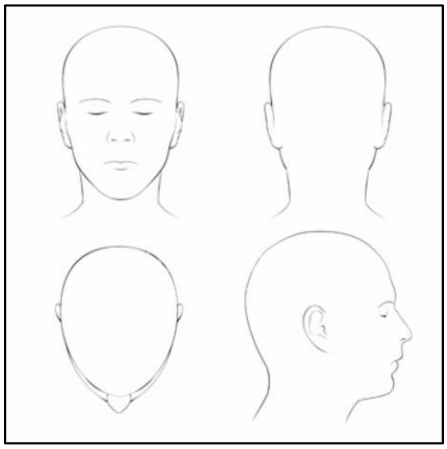
Give a Brief Description of your Injury/Complaint (Include how it was sustained):

_____

_____

_____

Date of Injury/Symptom Onset: _____



For Head/Neck Pain:

On the drawings to the right, please mark painful areas with symbols given:

X Sharp & Stabbing	△ Burning	⟋⟍ Pins & Needles
S Dull Ache	○ Numb	= Stiff & Tight
☆ Pressure	# Throbbing	

Rate the following by circling a number:

Level of pain **now:** None 0 1 2 3 4 5 6 7 8 9 10 Worst ever felt

Level of pain **at its worst:** None 0 1 2 3 4 5 6 7 8 9 10 Worst ever felt

Is your pain: ☐ constant ☐ intermittent/random ☐ activity dependent ☐ not sure

POST CONCUSSION SYMPTOM SCALE

Please Indicate how you are feeling based on the **last 2 days:**

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

Overall, is your pain getting ☐ better? ☐ worse? ☐ staying relatively constant?

Have you sought medical evaluation for your current complaint before now? ☐ Yes ☐ No
If yes, indicate type: ☐ Family MD ☐ Sport MD ☐ Emerge MD ☐ Walk-in MD ☐ Other_____

Have you had any imaging for your current complaint (Xray, CT, MRI)? ☐ Yes ☐ No

Please list any medications, or supplements (e.g. vitamins) you are currently taking (including over-the-counter):
_____
Do any of the conditions below apply to you? ☐ None
☐ ADHD ☐ Depression ☐ Migraine ☐ Learning Disability ☐ Sleep Disorder ☐ Anxiety

Are you currently experiencing any ongoing medical conditions not listed?_____

Have you had a routine eye exam in the last year? ☐ No ☐ Yes

PAST HEALTH HISTORY

Have you sustained any previous Concussions? ☐ No ☐ Yes If yes, indicate when they occurred and length of recovery:
_____
_____
_____
_____

Please indicate any previous surgeries, hospitalizations, fractures, or traumas (other than concussion) (include year):
_____
_____
_____

FAMILY HEALTH HISTORY

Have you or anyone in your immediate family had any of the following (please check those that apply):
☐ Heart disease ☐ High blood pressure ☐ Cancer ☐ Diabetes ☐ Stroke ☐ Other Disease _____

Name:	Family Physician/ Location: DR.	Date of Birth: (M/D/YR)
Mailing Address / Postal Code:		
Home Telephone Number:	Cell Phone Number:	
Emergency Contact and 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 $60 will be charged to your account.

I hereby agree that I will pay for any missed or cancelled appointments at a fee of $60/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: _____