Ridgefield Pediatric Associates, P.C.
ImpACT Testing Questionnaire

Section I

Please answer the following general questions about your child.

Name:  
Date of Birth:  
Gender:  
Handedness:  

Age:  
Height (ft and in):  
Weight:  

Native Country/Region:  
Native Language:  

Second Language:  
Years Speaking:  

Years of Education Completed  
Excluding Kindergarten:  
Received Speech Therapy:  
Attended Special Education  
Classes:  

Repeated One or More Years of School:  
Diagnosed Learning Disability:  
Problems with  
ADD/Hyperactivity:  

What Type of Student (circle one):  
Average  Above Average  Below Average  

Current Sport:  

Current Level of Participation:  

Primary Position/Event/Class:  

Years of Experience at this Level:  

Section II

Please answer the following questions regarding your child’s health history.
Number of times diagnosed with a concussion (excluding current injury):

Concussions that resulted in loss of consciousness:

Concussions that resulted in confusion:

Concussions that resulted in difficulty remembering events that occurred immediately after injury:

Concussions that resulted in difficulty remembering events that occurred:

Total games missed as a result of all concussions combined:

Concussion history (please list approx dates):

| Treatment for Headaches by Physician: | History of Meningitis: |
| Treatment for Migraine Headaches by Physician: | Treatment for Substance/Alcohol Abuse: |
| Treatment for Epilepsy/Seizures: | Treatment for Psychiatric Condition (Depression, Anxiety): |

History of Brain Surgery:

| Diagnosed with ADD/ADHD: | Diagnosed with Autism: |
| Diagnosed with Dyslexia: | Strenuous Exercise in the Last 3 Hours: |

| Number of Hours Sleep Last Night: | Current Medications: |

Section III

Please complete the following section together with your child. On a scale of 0 to 6 (0 being the least and 6 being the most) please rate the following symptoms your child is currently experiencing. Please keep in mid this is referring to symptoms your child is experiencing at the present time, and not referring to symptoms experienced with past injuries.

| Headache: | Sensitivity to Noise: |
| Nausea: | Irritability: |
Vomiting:
Balance Problems:
Dizziness:
Fatigue:
Trouble Falling Asleep:
Sleeping More Than Usual:
Sleeping Less Than Usual:
Drowsiness:
Sensitivity to Light:

Sadness:
Nervousness:
Feeling More Emotional:
Numbness or Tingling:
Feeling Slowed Down:
Feeling Mentally Foggy:
Difficulty Concentrating:
Difficulty Remembering:
Visual Problems: