NCHSAA Concussion Injury History

Student-Athlete's Name: _____ Sport: _____ Male/Female

Date of Birth: _____ Date of Injury: _____ School: _____

Following the injury, did the athlete experience:	Circle one	Duration (write number/ circle appropriate)	Comments
Loss of consciousness or unresponsiveness?	YES | NO	_____ seconds / minutes / hours	
Seizure or convulsive activity?	YES | NO	_____ seconds / minutes / hours	
Balance problems/unsteadiness?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Dizziness?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Headache?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Nausea?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Emotional Instability (abnormal laughing, crying, anger?)	YES | NO	_____ minutes / hrs / days / weeks/ continues	
Confusion?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Difficulty concentrating?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Vision problems?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Other _____ _____	YES | NO	_____ minutes / hrs / days / weeks /continues	

Describe how the injury occurred: _____

_____

_____

Additional details: _____

_____

_____

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Name of person completing Injury History: _____

Contact Information: Phone Number: _____ Email: _____

Injury History Section completed by: Licensed Athletic Trainer, First Responder, Coach, Parent, Other **(Please Circle)**

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