34474-08

Children's Healthcare of Atlanta
Children's Physician Group - Orthopaedics

CONCUSSION OFFICE VISIT

Name___________________________________

Date of Birth______________________________

MRN#__________________________________

Account/HAR#____________________________
PATIENT IDENTIFICATION

Accompanied by: ____ Mother ____ Father ____ Guardian ____ Other

Name: ______________________________ Nickname: _________________________________

Date of Birth: _____/_____/______ Age in years: ___________

School: __________________________________ Sport/Position: ____________________________

Date of Injury: _____/_____/______

Evaluated at what Emergency Room? _________________________ Date: _____/_____/_____

What tests were done: CT/X-rays Results: ____

Referred by: __________________________ Athletic Trainer: _________________________________

Grades in school: (Circle one) Honor's A's A/B's B's B/C's C's Below C's

Parent's email: ____

History of Previous Concussions? Date(s): ____

Diagnosed with: (Circle) Anxiety Depression Migraines ADHD ADD Headaches
Headaches Epilepsy/seizures Learning Disorders

Briefly describe what happened:

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Parent/Patient/Legal Guardian Signature: _______________________________ Date:_______ Time:_______

For Doctor Use:

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Provider/Physician Signature: ____ Date: _______ Time: _______