

**Ridgefield Pediatric Associates, P.C.**  
**ImPACT Testing Questionnaire**

**Section I**

Please answer the following general questions about your child.

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Name:

Age:

Date of Birth:

Height (ft and in):

Gender:

Weight:

Handedness:

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Native Country/Region:

Second Language:

Native Language:

Years Speaking:

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Years of Education Completed  
Excluding Kindergarten:

Repeated One or More Years of  
School:

Received Speech Therapy:

Diagnosed Learning Disability:

Attended Special Education  
Classes:

Problems with  
ADD/Hyperactivity:

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

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Current Sport:

Current Level of Participation:

Primary Position/Event/Class:

Years of Experience at this Level:

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**Section II**

Please answer the following questions regarding your child's health history.

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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):

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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:

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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:

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### **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 mind this is referring to symptoms your child is experiencing at the present time, and not referring to symptoms experienced with past injuries.

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Headache:

Sensitivity to Noise:

Nausea:

Irritability:

Vomiting:

Sadness:

Balance Problems:

Nervousness:

Dizziness:

Feeling More Emotional:

Fatigue:

Numbness or Tingling:

Trouble Falling Asleep:

Feeling Slowed Down:

Sleeping More Than Usual:

Feeling Mentally Foggy:

Sleeping Less Than Usual:

Difficulty Concentrating:

Drowsiness:

Difficulty Remembering:

Sensitivity to Light:

Visual Problems:

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