Patient/Athlete Name: _____ Date of Birth:____/_____/____(dd/mm/yy)

Age: _____ Parent Name: _____ Phone: _____

Grade in School: _____ Dominant Writing Hand: _____

Sports you actively participate in (all seasons): _____

CONFIDENTIAL MEDICAL INFORMATION AND CONCUSSION HISTORY

Please complete the following questions as accurately as possible in order to help us effectively interpret the results of your baseline assessment. This information will remain strictly confidential.

Do you have any of the following conditions? (please indicate)

☐ Receiving extra accommodation to help you learn in school

☐ ADD/ADHD ☐ Clinical Depression/Anxiety ☐ Learning Disability ☐ Sleep Disorder ☐ Dyslexia

☐ Visual Condition: _____

Concussion History: include month/year, how it happened, symptoms experienced, and length of recovery:

☐ known concussions

_____

_____

_____

_____

PLEASE REVIEW BELOW, SIGN

I hereby consent to the administration and supervision of a concussion baseline test by *Shift Concussion Management*. I understand that baseline testing does not prevent concussion injuries, but allows healthcare professionals to better manage the injury, should it occur.

_____ _____ _____

SIGNED PRINT NAME DATE

For Athletes under the age of 16: PLEASE HAVE PARENT/GUARDIAN SIGN ABOVE*

281 Stone Rd. E suite 103 • Guelph, ON • N1G 5J5 concussion@theshift.ca / 1-855-223-1002