UCSF Sports Concussion Clinic Appointment Request

UCSF Health
Orthopaedic Institute

Patient Name (last name, first name)

If making an appointment for a child:

Your Last Name, First Name

Child's School & Grade:

Patient Date of Birth:

Insurance Provider & Group:

Do you have a Referral from a primary care provider or pediatrician?

- ◯ Yes
- ◯ No

Patient e-mail (If scheduling for a child, parent's e-mail):

Daytime Phone:

Alternative Phone:

Date of Injury:

Describe how injury occurred:

Has the patient sought treatment for this injury?

- ◯ Yes
- ◯ No

If yes, who did the patient see and when?

Has the patient had a brain MRI or CT scan done?

- ◯ Yes
- ◯ No

If yes, when was the imaging done and did the imaging find anything abnormal?

What is the primary reason for scheduling?

What are the patient's current symptoms?

- ☐ Headache
- ☐ Balance Problems
- ☐ Anxiousness/Nervousness
- ☐ Difficulty Focusing
- ☐ Dizziness or Vertigo
- ☐ Fatigue
- ☐ Difficulty Remembering
- ☐ Vision Issues

Have your symptoms kept you out of school/work?

- ◯ Yes
- ◯ No

What sports or other activities are the patient involved in?