APS ATHLETICS
Great for Kids!

Athlete _____
Sport/Level _____
Date/Time _____
Evaluator _____

Concussion Evaluation

Injury Characteristics: Description of Injury _____

Is there evidence of: a) forcible blow to head (direct/indirect) Y / N / U b) intracranial injury or skull fracture Y / N / U

Location of impact: (Circle) Frontal Temporal Lt Rt Parietal Lt Rt Occipital Neck Indirect Force Other _____

Post Concussion Symptom Scale: Rate each symptom: 0 None 1-2 Mild 3-4 Moderate 5-6 Severe

Headache	☐	Trouble falling asleep	☐	Sadness	☐	Difficulty Concentrating	☐
Nausea	☐	Sleeping more than usual	☐	Nervousness/Anxious	☐	Difficulty Remembering	☐
Vomiting	☐	Drowsiness	☐	Numbness/Tingling/Neck Pain	☐	Burred Vision	☐
Balance Problems	☐	Sensitivity to Light	☐	Feeling Slowed Down	☐	Pressure in Head	☐
Fatigue/Low Energy	☐	Sensitivity to Noise	☐	Feeling like "in a fog"	☐	Other	☐

Balance Error Scoring System:

Type of Errors

1) Hands lifted off iliac crest 2) Opening eyes
3) Step, Stumble, or fall 4) Lifting forefoot or heel
5) Moving hip into >30 abduction
6) Remaining out of testing position > 5 sec.

BESS Score Card Firm Foam/Surface

Double leg	☐	☐
Single leg	☐	☐
Tandem Leg	☐	☐
Total	☐	

Orientation : (Pass/Fail)

What month is it?	☐
What's the date today?	☐
What 's the day of the week?	☐
What year is it?	☐
What time is it right now? (within 1 hr.)	☐

Memory: (Pass / Fail)

Trial	1	2	3
Word 1 _____	☐	☐	☐
Word 2 _____	☐	☐	☐
Word 3 _____	☐	☐	☐
Word 4 _____	☐	☐	☐
Word 5 _____	☐	☐	☐
Sub Total	☐	☐	☐
Total	☐		

Concentration: (Digits Backwards) (P-PASS/ F-FAIL / DNC-DID NOT COMPLETE)

2-3-5	_____	☐	4-9-3	_____ ☐
3-8-1-4	_____	☐	3-2-7-9	_____ ☐
6-2-9-7-1	_____	☐	1-5-2-8-6	_____ ☐
7-1-8-4-6-2	_____	☐	5-3-9-1-4-8	_____ ☐

Months in Reverse Order:

Dec-Nov-Oct-Sept-Aug-Jul-Jun-May-Apr-Mar-Feb-Jan ☐

EXERTION If the subject is not displaying or reporting symptoms, create conditions under which the symptoms are likely to be elicited and detected.
These measures need not be conducted if a subject is already displaing or reporting any symptoms.

Physical Activity (symptoms worsen) ____Yes ____No ____N/A

Cognitive Activity (symptoms worsen) ____Yes ____No ____N/A

Neurologic Screening: (Yes — No — Unknown)

Loss of Consciousness/Unresponsiveness Y N U Length _____ Tinnitus Y N U

Post-Traumatic Amnesia Y N U Length _____ Vertigo Y N U

Retrograde-Traumatic Amnesia Y N U Length _____

(list as N for normal AB of Abnormal)

Strength: Extremity: Rt upper _____ Lt upper _____ Rt Lower _____ Lt Lower _____

Sensation (Romberg) _____ Coordination (Tandem walk/ finger-nose-finger) _____

History: Prior Concussion(s) {# / When} _____ _____ _____

Recall

☐	Word 1
☐	Word 2
☐	Word 3
☐	Word 4
☐	Word 5

Diagnosis Concussion Other

Action Plan: Instructions _____

Release to: (whom/how) _____ _____

Advised follow up _____ _____

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Concussion Evaluation Instruction Guide

Injury Characteristics: 1) Record Date/ Time Evaluator / Description of Injury/ Evidence (if any) Location of Impact Complete History— Other concussions, other issues etc.

Introduction: I am going to ask you some questions. Please listen carefully and give your best effort.

Post Concussion Symptom Scale: Each condition should be rated by the student athlete on the scale as follows:

0 = no symptom 1-2 Mild symptom 3-4 Moderate symptom 5-6 Severe symptom

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Balance Error Scoring System: The BESS is calculated by adding one error point for each error during the six 20-second tests.

Type of Errors: 1) Hands lifted off iliac crest 2) Opening eyes 3) Step, Stumble, or fall 4) Lifting forefoot or heel
5) Moving hip into >30 abduction 6) Remaining out of testing position > 5 sec.

Orientation : (Pass/Fail) Answer each question to your best effort. 1) Month 2) Today's date 3) Day of week 4) Year 5) Time (within hour)

Memory: (Pass/Fail) I am going to test your memory. I will read you a list of words and whdn I am done, Repeat back as many words as you can remember, in any order. Perform Trial # 1

Trials 2 & 3: I am going to repeat that list again. Repeat back as many words as you can remember, in any order, even if you said the word before.

Complete all 3 trials regardless of score on trial 1 & 2.

Concentration: (Pass/Fail) I am going to read you a string of numbers and when I am done, you repeat them back to me backwards, in reverse order of how I read them to you. For example, if I say 7—1—9 , you would say 9—1– 7. (If correct, go to next string length. If incorrect, read trial 2. Stop after incorrect on both trials.)

Months:(Pass/Fail) Now tell me the months of the year in reverse order. Start with the last month and go backwards. Example: So you'll say Dec., Nov.,...Go ahead.

EXERTION If the subject is not displaying or reporting symptoms, create conditions under which the symptoms are likely to be elicited and detected.
<u>These measures need not be conducted if a subject is already displaying or reporting any symptoms.</u>

(If not conducted, allow 2 minutes to keep time delay constant before testing Delayed Recall.)

These methods should be administered for the baseline testing of normal subjects. 5 Jumping Jacks — Sit ups—Push ups—Knee Bends

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Delay Recall: (Pass / Fail) Do you remember the list of words I read a few times earlier? Tell me as many words from the list as you can remember in any order.

Neurologic Screening: (Yes **Y** — No **N** — Unknown **U**) Record neurologic screening on evaluation page.

Diagnosis: Treated as Head Trama/Concussion: _____ Follow protocol. Other Condition_____

Action Plan: Record all instructions you sent; Whom and how athlete was released, and advised follow-up.

NOTES: