SUTTON
SPECIAL RISK

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CONCUSSION QUESTIONNAIRE – TO BE COMPLETED BY PHYSICIAN

Player's Name: **Age:**

How many concussions has the player suffered? Please give dates of concussions.	Details:
Indicate seriousness of concussions.	Details:
Did the player suffer any loss of consciousness in any of the incidents?	Details:
Detail the player's condition at the time of incident.	Details:
Was the player hospitalized? If so, for how long.	Details:
Did you prescribe any medication? If so, what was prescribed and what was the dosage.	Details:
Was a CAT scan performed (if yes, please provide results).	
What was the player's condition upon release.	Details:
How many games did the player miss with each incident?	Details:

Please indicate any symptoms suffered by the player immediately following the incident:

Headaches	☐ Yes	☐ No	Loss of Memory	☐ Yes	☐ No
Blurred Vision	☐ Yes	☐ No	Ringing in Ears	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Cognitive Changes	☐ Yes	☐ No
			Language Difficulty	☐ Yes	☐ No
Other (please explain)					

month day year

Physicians Signature