SUTTON
SPECIAL RISK

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CONCUSSION QUESTIONNAIRE – TO BE COMPLETED BY PLAYER

Name: **Age:**

How many concussions have you suffered? Please give dates of concussions.	Details:
Did you suffer any loss of consciousness in any of the incidents?	Details:
Were you hospitalized? If so, for how long.	Details:
What was your condition upon release?	Details:
Were you prescribed any medication? If so, what was prescribed and what was the dosage	Details:
Do you wear a mouthguard?	
How many games did you miss with each incident?	Details:

Please indicate any symptoms you suffered 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

Player Signature