Gfeller-Waller/NCHSAA Concussion Injury History Form

Name of Athlete: _____ Sport: _____

DOB: _____ Date of Injury: _____ School: _____

Following the injury, did the athlete experience:	Circle one	Duration (write number/ circle appropriate)
Lying motionless on the playing surface?	YES | NO | UNSURE	
Falling unprotected to the surface?	YES | NO | UNSURE	
Actual or suspected loss of consciousness or unresponsiveness?	YES | NO | UNSURE	_____ min / hrs
Seizure, tonic posture (sudden tension or stiffness), or convulsive activity?	YES | NO | UNSURE	_____ min / hrs
Ataxia (poor voluntary muscle control i.e. stumbling, off-balance, speech difficulty)	YES | NO | UNSURE	_____ hrs / days / weeks /continues
Vomiting?	YES | NO | UNSURE	_____ hrs / days / weeks /continues
The above signs strongly suggest concussion, but could indicate a more serious condition or injury. If there is concern about a more serious injury, consider seeking rapid evaluation by a licensed healthcare provider.		
Disorientation or confusion, inability to respond appropriately to questions?	YES | NO | UNSURE	_____ hrs / days / weeks /continues
Gait unsteadiness?	YES | NO | UNSURE	_____ hrs / days / weeks /continues
Dizziness?	YES | NO | UNSURE	_____ hrs / days / weeks /continues
Headache?	YES | NO | UNSURE	_____ hrs / days / weeks /continues
Nausea?	YES | NO | UNSURE	_____ hrs / days / weeks /continues
Emotional lability (inappropriate laughing, crying, anger, etc?)	YES | NO | UNSURE	_____ hrs / days / weeks / continues
Amnesia?	YES | NO | UNSURE	_____ min / hrs / days / weeks /continues
Difficulty focusing, concentrating, or remembering?	YES | NO | UNSURE	_____ hrs / days / weeks /continues
Vision problems?	YES | NO | UNSURE	_____ hrs / days / weeks /continues
Light Sensitivity?	YES | NO | UNSURE	_____ hrs / days / weeks /continues
Noise Sensitivity?	YES | NO | UNSURE	_____ hrs / days / weeks /continues
Other :_____	YES | NO | UNSURE	_____ hrs / days / weeks /continues

Describe how the injury occurred: _____

_____

_____

Additional details: _____

_____

Person completing Injury History Section: Licensed Athletic Trainer, First Responder, Coach, Parent, Other (Please Circle)

Name of person completing Injury History: _____

Phone Number: _____ Email: _____

Revised July 2024