ImPACT Test Demographics – Cheat Sheet

Preferred language: (Circle) English Spanish French

The ImPACT testing process is made up of three components:

1. Sport and Health History
2. Current Symptoms and Conditions
3. Neurocognitive Testing

Sport and Health History

General Information
Language
Education
Sports
Concussion History

Organization – drop down menu
PYFL

Date of Birth – drop down menu
MM_____ / DD_____ / YYYY_____

First Name_____

Last Name_____

Height – drop down menu Feet_____ Inches_____

Weight – in pounds Pounds_____

Gender: (Circle) Male or Female

Handedness: (Circle) Right or Left or Ambidextrous(Both right and left)

Address: Street or P.O. Box_____
City_____ State__ME__ Zip Code_____
Country___United States___
Email Address – Optional (Should be the athlete taking the test) _____

Native Country – ___United States___ - can change with drop down menu
Native Language - ___English___ - can change with drop down menu
Second Language – can choose from drop down menu

Ethnicity – optional - (Circle) – Click on computer
American Indian or Alaska Native
Asian
Black or African American
Hispanic or Latino
Native Hawaiian or other Pacific Islander
White

Years of education completed excluding kindergarten – _____ - Drop down menu
(e.g. 6th grader = 5; 7th grader = 6; 8th grader = 7)

Circle any of the following that apply: (Click on computer)

Received Speech Therapy
Attended special education classes
Repeated one or more year(s) of school
Diagnosed learning disability
Diagnosed attention deficit disorder or hyperactivity

While in school, what type of student were/are you? (circle) – click on computer

Below average
Average
Above average

Current Sport – Drop down menu to Football

Current position – type in Offense or Defense or position or leave blank

Current level of participation: drop down to Junior High

Years of experience at this level: Drop down to number

Please approximate if uncertain and do not include current year;
(e.g. 6th grader = 5; 7th grader = 6; 8th grader = 7)

Previous Concussion History: Drop down menu to get number

_____ Number of times diagnosed with a concussion.
_____ Total number of concussions that resulted in loss of consciousness.
_____ Total number of concussions that resulted in confusion.
_____ Total number of concussions that resulted in difficulty with memory for events occurring immediately after injury.
_____ Total number of concussions that resulted in difficulty with memory for events occurring immediately before injury.
_____ Total games were missed as a direct result of all concussions combined.

Please list your five most recent concussions, if applicable. Use approximate dates if necessary.

Drop down menu for: Month_____ Year_____
Click **Add Date** to list more concussions.

Indicate whether you have experienced the following: (Circle Yes or No – click on computer)

Yes / No Treatment for headaches by physician
Yes / No Treatment for migraine headaches by physician
Yes / No Treatment for epilepsy/seizures
Yes / No Treatment for brain surgery
Yes / No Treatment for meningitis
Yes / No Treatment for substance/alcohol
Yes / No Treatment for psychiatric condition (depression/anxiety)

Have you ever been diagnosed with any of the following conditions?

(Circle Yes or No – click on computer)

Yes / No ADD/ADHD

Yes / No Dyslexia

Yes / No Autism

Have you participated in any strenuous exercise and/or exertion in the last three hours?

Yes / No (Circle Yes or No – click on computer)

Date of last concussion: Drop down menu

MM_____ / DD_____ / YYYY_____

Hours of sleep last night: Drop down menu

Hours_____

List Current Medications: Type in list

_____

_____

_____

_____

_____