BEACON COLLEGE

Office of Health Promotion
105 East Main Street
Leesburg, Florida 34748
Phone (855) 220-5376
Fax (352) 787-0796
mybeaconhealth@beaconcollege.edu

Athlete History Supplement for Athletes with Disabilities

Name: _____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disabliity (birth, disease, injury, or other):		
5. List of sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device or daily activitues?		
7. Do you use any special brace or assistive device in sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have any buring or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here: _____

Please indicate whether you have ever had any of the following conditions:

	Yes	No
1. Atlantoaxial instability		
2. Radiographic (x-ray) evaluation for atlantoaxial instability		
3. dislocated joints (more the one)		
4. Easy bleeding		
5. Enlarged spleen		
6. Hepatitis		
7. Osteopenia or osteoporosis		
8. Difficulty controlling bowel		
9. Difficulty conrtolling blatter		
10. Numbness or tingling in arms or hands		
11. Numbness or tingling in legs or feet		

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	Yes	No
12. Weakness in arms or hands		
13. Weakness in legs or feet		
14. Recent change in coordination		
15. Recent change in ability to walk		
16. Spina bifida		
17. Latex allergy		

Explain "Yes" answers here: _____

_____

_____

_____

I hereby stae that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

_____ _____ _____

Signature of athlete | Signature of parent or guardian | Date

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Concussion Evaluation Form

Athlete Name: _____ Time: _____

Date of Injury: _____ Today's Date: _____

- **Grade the 22 symptoms with a score of 0 through 6.**
  - *Note that these symptoms may not all be related to a concussion.*
- You can fill this out at the beginning of the season as a baseline (after a good night's sleep).
- If you suspect that you have a concussion, use this checklist to record your symptoms.
- You can track your symptoms as you recover.
  - *There is no scale to which to compare your total score; your score is individualized to you.*
- Show your baseline (if available) and any follow-up checklists to your physician.

❑ Baseline Score
❑ Post Concussion Score

	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck pain	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
More emotional than usual	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or anxious	0	1	2	3	4	5	6
TOTAL SUM OF EACH COLUMN							
TOTAL SYMPTOM SCORE (sum of all column totals)							

Student's Full Name: _____ Date of Birth: ____/____/____

Sport: _____ Coach: _____

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