This concussion supplement is a guideline to be used for athletes who answer YES to any questions between 9 - 14 on the PPE form (©2010, American Academy of Family Physicians, et al), or have a known history of concussion or indicators for further evaluation. (4/11/18)

NAME: **DATE:**

Previous Concussion or Concussion symptoms lasting more than one day Date: Date:	Type of symptoms (describe)	Severity of symptoms (0-6)	Duration of symptoms (hours/days/weeks)	LOC/Amnesia (Y/N)	Convulsions/Seizures (Y/N)
All symptoms resolved (Y/N) If yes, list date If no, describe					
History of migraines or sleep disturbances? (Y/N) If yes, describe					
Ongoing difficulty w school/grades? (Y/N) If yes, describe					