Player Application Concussion Intensive Program

Instructions: Upon meeting criteria for participation, please complete this form entirely. Return by mail or email:
The Dr. John E. Upledger Foundation 11211 Prosperity Farms Road, D-225 Palm Beach Gardens, FL 33410
Phone: 561.622.4588 **Fax**: 561.627-9231 **Email**: Clinic@iahe.com

Player Criteria for Participation:

- Post Concussion Syndrome diagnosed by an MD.
- The player must not currently be having acute signs of concussive symptoms.
- To keep the study inclusive the player needs to be a retired professional football player
- The number of concussions can be varied amongst the participants.
- Ages can be varied.

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____

Email: _____ Phone: _____

*Please circle **yes** or **no** for the questions below.*

1. Have you ever been diagnosed with a *concussive head injury*? TBI? Or Post Concussive Syndrome? YES / NO

2. Have you been tested for neurocognitive dysfunction (Impact Test, Dynavision Test, King-Devick Test)? YES / NO

3. Have you ever been tested for sleep disorder? YES / NO

4. Do you have brain studies such as MRI, fMRI, Spect Scan, CT, Neurofeedback, Mapping, or Tissue Density? YES / NO

Background

1. Position you played during your athletic career?

_____

_____

2. How many concussions have you had?

_____

_____

_____

3. When was the most recent concussion?

_____

_____

4. How long was your recovery from each concussion?

_____

_____

_____

5. Do you have any learning/reading comprehension problems?

_____

_____

6. Have you ever been diagnosed with or had feelings of depression or anxiety?

_____

_____

_____

7. Are you on any medication now? If so, please list medications.

_____

_____

8. Do you complain of dizziness now or in the past?

_____

_____

_____

Symptom Evaluation - How do you feel?

You should score yourself on the symptoms based on how you feel <u>now</u>.

None = 0	Mild = 1 – 2	Moderate = 3 – 4	Severe = 5 – 6

Symptom	**Where**	**Score**
Headache		
Pain		
Weakness/Numbness		
Loss of Range of Motion		
Fatigue Easily		
Balance Disorder		
Sleep Disorder		
Eating Disorder		
Digestion Problems		
Elimination Problems		
Difficulty with Memory		
Abnormal Behavior		
Difficulty Making Decisions		
Confusion		
Seizures		
Slurred Speech		
	Total Score	

Please add to the above list any symptoms that were not mentioned:

_____

_____

Applicant Signature: _____ Date: _____

On behalf of everyone at the International Association of Healthcare Educators, we would like to pass on our thanks to you for your interest in participating in our Concussion IP November 2018.