**Demographic and Background Information**

Test Language: _____________________________________________________________

First Name: ___________________________________ Last Name: _______________________

Date of Birth: _____Month _____ Date _____Year

Gender: _____ Male _____ Female

Pointing Device: ____ Mouse ____ Trackpad ____ Unsure

Have you ever been diagnosed with attention deficit disorder or hyperactivity? _____ Yes _____ No

Have you ever been diagnosed with a learning disability? _____ Yes _____ No

Have you had a concussion in the last 6 months? _____ Yes _____ No

Native Country / Region: _______________________________________________________

Native Language: _____________________________________________________________

Second Language: ________________________________ (only if fluent in speaking and writing)

Years of education completed excluding kindergarten: _______
(e.g., high school senior is 11 years)

Check any of the following that apply:

_____ Received speech therapy

_____ Attended special education classes

_____ Repeated one or more years of school

While in school, what type of student were / are you?

_____Below Average _____Average _____Above Average

Current Sport: _______________________________________________________________

Current position / event / class: ___________________________
(e.g., quarterback, forward, 1st base, etc.)

Current level of participation: ____________________________(e.g., junior high, high school)

Years of experience at this level: _______ (0 - 4)
(e.g., number of years in high school, high school senior = 3)
Concussion History

- Number of times diagnosed with a concussion (excluding current injury)
- 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 that occurred immediately after injury
- Total number of concussions that resulted in difficulty with memory for events that occurred immediately before injury
- Total number of games that were missed as a direct result of all concussions combined

Indicate whether you have been treated for the following:

- Yes No Headaches by physician
- Yes No Migraine headaches by physician
- Yes No Epilepsy / seizures
- Yes No Brain surgery
- Yes No Meningitis
- Yes No Substance abuse / alcohol abuse
- Yes No Psychiatric condition (depression, anxiety)

Have you been diagnosed with any of the following?

- Yes No Dyslexia
- Yes No Autism

Have you participated in any strenuous exercise and/or exertion in the last three hours? Yes No

Date of your last concussion: ________ month ______ date _____ year

Hours of sleep last night (approximate if uncertain): ______

Please list any PRESCRIPTION medication(s) you are currently taking:

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________