Acute Concussion Evaluation (ACE)

Physician/Clinician Office Version

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Patient Name:_____
DOB: _____ Age:_____
Date:_____ ID/MR#_____

A. Injury Characteristics **Date/Time of Injury**_____**Reporter: __Patient __Parent __Spouse __Other**_____

1. Injury Description _____

_____

1a. Is there evidence of a forcible blow to the head (direct or indirect)? __Yes __No __Unknown
1b. Is there evidence of intracranial injury or skull fracture? __Yes __No __Unknown
1c. Location of Impact: __Frontal __Lft Temporal __Rt Temporal __Lft Parietal __Rt Parietal __Occipital __Neck __Indirect Force

2. Cause: __MVC __Pedestrian-MVC __Fall __Assault __Sports (*specify)*_____Other_____

3. Amnesia Before (Retrograde) Are there any events just BEFORE the injury that you/ person has no memory of (even brief)? __ Yes __No Duration

4. Amnesia After (Anterograde) Are there any events just AFTER the injury that you/ person has no memory of (even brief)? __ Yes __No Duration

5. Loss of Consciousness: Did you/ person lose consciousness? __ Yes __No Duration

6. EARLY SIGNS: __Appears dazed or stunned __Is confused about events __Answers questions slowly __Repeats Questions __Forgetful (recent info)

7. Seizures: Were seizures observed? No__ Yes___ Detail_____

B. Symptom Check List* Since the injury, has the person experienced any of these symptoms any more than usual today or in the past day?

Indicate presence of each symptom (0=No, 1=Yes). ***Lovell & Collins, 1998 JHTR***

PHYSICAL (10)		COGNITIVE (4)		SLEEP (4)	
Headache	0 1	Feeling mentally foggy	0 1	Drowsiness	0 1
Nausea	0 1	Feeling slowed down	0 1	Sleeping less than usual	0 1 N/A
Vomiting	0 1	Difficulty concentrating	0 1	Sleeping more than usual	0 1 N/A
Balance problems	0 1	Difficulty remembering	0 1	Trouble falling asleep	0 1 N/A
Dizziness	0 1	**COGNITIVE Total (0-4)** _____		**SLEEP Total (0-4)** _____	
Visual problems	0 1	**EMOTIONAL (4)**			
Fatigue	0 1	Irritability	0 1		
Sensitivity to light	0 1	Sadness	0 1		
Sensitivity to noise	0 1	More emotional	0 1		
Numbness/Tingling	0 1	Nervousness	0 1		
PHYSICAL Total (0-10) _____		**EMOTIONAL Total (0-4)** _____			
(Add Physical, Cognitive, Emotion, Sleep totals) Total Symptom Score (0-22)		_____			

Exertion: Do these symptoms worsen with:
Physical Activity __Yes __No __N/A
Cognitive Activity __Yes __No __N/A

Overall Rating: How different is the person acting compared to his/her usual self? (circle)

Normal 0 1 2 3 4 5 6 Very Different

C. Risk Factors for Protracted Recovery *(check all that apply)*

Concussion History? Y ___ N___	√	Headache History? Y ___ N___	√	Developmental History	√	Psychiatric History
Previous # 1 2 3 4 5 6+		Prior treatment for headache		Learning disabilities		Anxiety
Longest symptom duration Days__ Weeks__ Months__ Years__		History of migraine headache __ Personal __ Family_____		Attention-Deficit/ Hyperactivity Disorder		Depression
						Sleep disorder
If multiple concussions, less force caused reinjury? Yes__ No__		_____		Other developmental disorder_____		Other psychiatric disorder _____

List other comorbid medical disorders or medication usage (e.g., hypothyroid, seizures)_____

_____

D. RED FLAGS for acute emergency management: Refer to the emergency department with sudden onset of any of the following:

- *** Headaches that worsen**
- *** Seizures**
- *** Focal neurologic signs**
- *** Looks very drowsy/ can't be awakened**
- *** Repeated vomiting**
- *** Slurred speech**
- *** Can't recognize people or places**
- *** Increasing confusion or irritability**
- *** Weakness or numbness in arms/legs**
- *** Neck pain**
- *** Unusual behavioral change**
- *** Change in state of consciousness**

E. Diagnosis (ICD): __Concussion w/o LOC 850.0 __Concussion w/ LOC 850.1 __Concussion (Unspecified) 850.9 __Other (854) _____
__No diagnosis

F. Follow-Up Action Plan **Complete *ACE Care Plan* and provide copy to patient/family.**

___ **No Follow-Up Needed**
___ **Physician/Clinician Office Monitoring**: Date of next follow-up _____
___ **Referral:**
___ Neuropsychological Testing
___ Physician: Neurosurgery____ Neurology____ Sports Medicine____ Physiatrist____ Psychiatrist____ Other_____
___ Emergency Department

ACE Completed by:_____