SCAT 3 For 13+ year old

BACKGROUND

Name: _____Date / time of injury: _____

Date of Assessment: _____Sport / team / school: _____

Age: _____Gender: __M__F

Current school year / grade: _____

Dominant hand: __Right __Left__ Neither

Mechanism of injury ("tell me what happened"?): _____

For Parent / caregiver to complete:

How many concussions do you think you have had in the past? _____

When was the most recent concussion? _____

How long was your recovery from the most recent concussion? _____

Have you ever been hospitalized or had medical imaging done (CT or MRI) for a head injury? __Y__N

Have you ever been diagnosed with headaches or migraines? __Y__N

Do you have a learning disability, dyslexia, ADD/ADHD, seizure disorder? __Y__N

Have you ever been diagnosed with depression, anxiety or other psychiatric disorder? __Y__N

Has anyone in the family ever been diagnosed with any of these problems? __Y__N

Are you on any medications? if yes, please list: __Y__N

_____

SYMPTOM EVALUATION How do you feel now? (compared to normal)

	Never	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	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

Do the symptoms get worse with physical activity? __Y__N
Do the symptoms get worse with mental activity? __Y__N

__ self rated __self rated and clinician monitored
__clinician interview __self rated with parent input