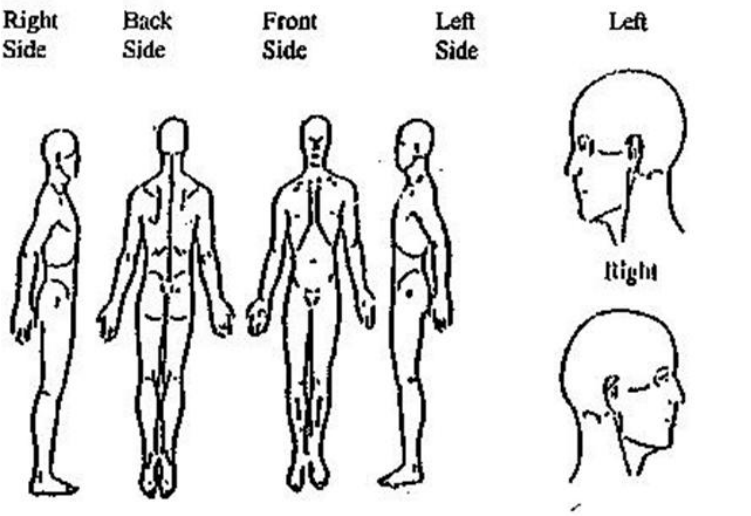
Happy Brain© Exam Form

Name_____ **Date**_____
Date of Injury/Onset: _____ **MVA?** Y N
Describe Injury:_____
_____
Blow to the head (direct or indirect)? Y / N Location? _____
Amnesia (before or After)? Y / N Loss of Consciousness? Y / N
Seizures? Y / N Vomitting? Y / N
Concussion History _____
Psychiatric History _____

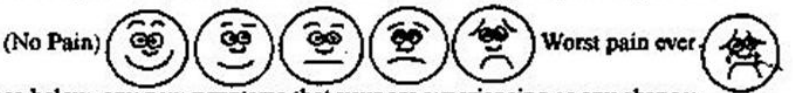
Subjective Complaints: [1-10 scale]
1. _____
2. _____
3. _____
4. _____

Condition described as: sharp dull ache throb numb tingle burn hot cold
Radiating to _____
How often? ____% of day **When?** AM PM
Complicating Factors: work / home

{Indicate areas of current pain and symptoms in the drawings below}



Please place one mark on the line below to indicate your present pain level:



Concussion Symptoms **{score** = ____/24}

Physical	**Physical**	**Cognitive**	**Emotional**	**Sleep**
Headache = ___/ 10	Numb/Tingle = __/ 10	Mentally Foggy = ___/ 10	Anger = ___/ 10	Drowsy = Y / N
Dizziness = ___/ 10	Light Sensitive = __/ 10	Slowed Down = ___/ 10	Depression = ___/ 10	Sleep More = Y / N
Fogginess = __/ 10	Noise Sensitive = __/ 10	Hard to Focus = ___/ 10	Irritability = ___/ 10	Sleep Less = Y / N
Nausea = __/ 10	Visual Changes = __/ 10	Memory Issues = ___/ 10	Nervousness = ___/ 10	Difficult Sleeping = Y / N
Fatigue = __/ 10	Balance Issues = __/ 10		Emotional = ___/ 10	Lights/tv/alarms/phone = Y / N

Cervical ROM
Flexion = ___/50 Extension = ___/60 Right Rotation = ___/80 Left Rotation = ___/80 Lt Lat Flex ___/45 Rt Lat Flex ___/45

Neurological Findings
VOR = __/ 4 Bite Test = L / R Cheek Puff Weak = L / R Neck Rotation Weakness = L / R Tongue Weakness = L / R

Visual Error Scoring System {score = _____}

Convergence = Unable to perform exam Nystagmus/twitching/blinking Symptoms aggravated _____
Pursuits =
[Horizontal] Unable to perform exam/Targeting issues Nystagmus/twitching/blinking Symptoms aggravated _____
[Vertical] Unable to perform exam/Targeting issues Nystagmus/twitching/blinking Symptoms aggravated _____
Saccades =
[Horizontal] Unable to perform exam/Targeting issues Nystagmus/twitching/blinking Symptoms aggravated _____
[Vertical] Unable to perform exam/Targeting issues Nystagmus/twitching/blinking Symptoms aggravated _____
Fixations =
[Horizontal] Unable to perform exam/Targeting issues Nystagmus/twitching/blinking Symptoms aggravated _____
[Vertical] Unable to perform exam/Targeting issues Nystagmus/twitching/blinking Symptoms aggravated _____

Balance Evaluation [Weakness / Loss of Balance when pushed]: Left = ___ Right = ___ Anterior = ___ Posterior = ___

Palpation Findings [Mild = underlined Moderate = circled Severe = + Acutely Severe = ++] [Tenderness and Spasms]
Trapezius/SCM SubOccipitals Temporalis Masseter First Cervical

Assessment: - Responding well Same as last visit Guarded Regressing _____

Diagnosis Concussion w/ LOC Concussion w/o LOC Post-Concusion Syndrome Abnormal Oculomotor Study Disorder of multiple cranial nerves
Dizziness Nausea Headache Muscle Spasm Muscle Weakness

Treatment **Cranial Compression** **Occipital Traction / Nodding** **Temporalis correction** **C1 correction** **Suboccipital correction**
Palming Exercise: ____ **Vertigo Maneuver:** Half Somersault ___ **Nutrition:** H2O _____ Omega3_____ Coconut oil _____ Vitamin D _____
Dynamic Cervical Stretches: _____ **Ball2wall:** _____
Strengthening: (cervcial isometrics) Flex = _____ Ext = _____ RLF = _____ LLF = _____ **Cardio:** _____ mins. at ___x/week
Response to care: _____ **Therapy Time:** _____ mins.

Treatment Plans
Phase of care: Acute Stabilization Maintainance Tests/Referal: Xray MRI Labs CT scan MD ND PT Specialists none expected
Goals: Reduce pain Increase ROM Strengthen Frequency of care: _____ times per _____ Expected duration: _____ days / weeks / months
Home Therapy RX: ice / heat massage brace/support elevate / rest diet stretch/strengthen Re-assess progress in _____ days weeks mo

Physician Signature _____ **Date**_____