

Gymnastics Concussion Baseline Information Sheet

Athlete Information

Full Name

Date of Birth

Age

Gymnastics Club

Coach Name

Competitive Level

Emergency Contacts

Parent/Guardian Name

Phone Number

Medical History

Previous Concussion(s)?

If yes, how many?

Other relevant medical conditions (e.g. migraines, ADHD, learning disability, etc.)

Current Medications

Baseline Symptom Checklist

Symptom	None	Mild	Moderate	Severe
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea/Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Memory Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble Sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotional Changes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Notes