ACUTE CONCUSSION EVALUATION (ACE)

Physician/Clinician Office Version

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Patient Name: RANDY ADAMS
DOB: 6/27/XX Age: 28
Date: TODAY ID/MR#: 12345

A. Injury Characteristics Date/Time of Injury: 08:00 2 WEEKS AGO Reporter: ✓Patient __Parent __Spouse __Other

1. Injury Description: HEAD INJURY IN A CAR ACCIDENT

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 2 minutes
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)	2	SLEEP Total (0-4)	1
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)	3	EMOTIONAL Total (0-4)	3		
(Add Physical, Cognitive, Emotion, Sleep totals) Total Symptom Score (0-22)		9/22			

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 MAYBE 4	✓	Prior treatment for headache		Learning disabilities		Anxiety
Longest symptom duration UNSURE Days__ Weeks__ Months__ Years__		History of migraine headache ✓Personal USES IMITREX __Family 2-4 EXPLOSIONS		Attention-Deficit/ Hyperactivity Disorder NA		Depression NA
If multiple concussions, less force caused reinjury? Yes__ No ✓				Other developmental disorder_____		Sleep 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	* Looks very drowsy/ can't be awakened	* Can't recognize people or places	* Neck pain
*Seizures	* Repeated vomiting	* Increasing confusion or irritability	* Unusual behavioral change
* Focal neurologic signs	* Slurred speech	* Weakness or numbness in arms/legs	* Change in state of consciousness

E. Diagnosis (ICD-10): __Concussion w/o LOC S06.0X0A ✓Concussion w/ LOC S06.0X1A __Concussion (Unspecified) S06.0X9A __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: _____ MD RN NP PhD ATC

RR 18 115/85
100% 98.6
65