Suite 420
33 Yonge Street
Toronto, Ontario
M5E 1S9
(416) 366-2223
Fax: 366-4608
Website: www.wjsutton.com

WILLIAM J. SUTTON & CO. LTD.

CONCUSSION QUESTIONNAIRE TO BE COMPLETED BY PLAYER

Name:	Age:

Question	Answer
How many concussions have you suffered? Please give dates of concussions.	
Did you suffer any loss of consciousness? If so, for how long.	
Were you hospitalized? If so, for how long.	
What was your condition upon release?	
Do you wear a mouth guard?	
Were you prescribed any medication? If so, what were you prescribed and what was the dosage.	
How many games did you miss?	
What was the length of recovery before participating in the next game?	

Please indicate any symptoms suffered **immediately following concussion**

Symptom			Symptom		
Headaches	☐ Yes	☐ No	Loss of Memory	☐ Yes	☐ No
Blurred Vision	☐ Yes	☐ No	Ringing in Ears	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Cognitive Changes	☐ Yes	☐ No
			Language Difficulty	☐ Yes	☐ No

Other (please explain)

Please indicate any symptoms suffered **after you were cleared to play**

Symptom			Symptom		
Headaches	☐ Yes	☐ No	Loss of Memory	☐ Yes	☐ No
Blurred Vision	☐ Yes	☐ No	Ringing in Ears	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Cognitive Changes	☐ Yes	☐ No
			Language Difficulty	☐ Yes	☐ No

Other (please explain)

Player Signature **Date**