

Did you have a head injury? Yes No ? If Yes, please complete below information.

**Military Acute Concussion
Evaluation (MACE)
Defense and Veterans Brain Injury Center
08/2006 DVBIC.org 800-870-9244
This form may be copied for clinical use.
Page of 6**

Patient Name: _____ SS#: _____ - _____ - _____

Unit: _____

Date of Injury: ____ / ____ / ____ Time of Injury: _____

Examiner: _____

Date of Evaluation: ____ / ____ / ____ Time of Evaluation: _____

History: (I – VIII)

I. Description of Incident

Ask:

- a) What happened?
- b) Tell me what you remember.
- c) Were you dazed, confused, “saw stars”? Yes No
- d) Did you hit your head? Yes No

II. Cause of Injury (Circle all that apply):

- 1) Explosion/Blast 4) Fragment
- 2) Blunt object 5) Fall
- 3) Motor Vehicle Crash 6) Gunshot wound
- 7) Other _____

III. Was a helmet worn?

Yes No Type _____

IV. Amnesia Before: Are there any events just BEFORE the injury that are not remembered?

(Assess for continuous memory prior to injury)

Yes No If yes, how long _____

V. Amnesia After: Are there any events just AFTER the injuries that are not remembered? (Assess time until continuous memory after the injury)

Yes No If yes, how long _____

VI. Does the individual report loss of consciousness or “blacking out”?

Yes No If yes, how long _____

VII. Did anyone observe a period of loss of consciousness or unresponsiveness?

Yes No If yes, how long _____

VIII. Symptoms (circle all that apply)

- 1) Headache 2) Dizziness
- 3) Memory Problems 4) Balance problems
- 5) Nausea/Vomiting 6) Difficulty Concentrating
- 7) Irritability 8) Visual Disturbances
- 9) Ringing in the ears 10) Other _____