

Attachment H

Phone Script for Injured Athlete Follow-up Interview

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Date _____
Interviewer Number _____

Soccer Concussion Subject Interview

For Parents: Hello, I am _____ calling about the sports concussion study.

If parent reported symptoms: *You reported that your child has symptoms of a concussion in the most recent weekly surveillance report. Is that correct?*

If no: review responses from weekly surveillance report.

If yes: *We'd like to get more information about the injury. Is now a good time to talk?*

If no, please call back at _____.

OR, if child reported symptoms:

Your child reported symptoms of a concussion in the most recent weekly surveillance report. Are you aware of this injury?

If no: *We will gather more information from your child about the injury. You will be notified if our physicians determine that the injury meets criteria for a concussion. Thank you for your time.*

[End interview]

If yes: *We'd like to get more information about the injury. Is now a good time to talk?*

If no, please call back at: _____.

For Athletes: Hello, I am _____ calling about the sports concussion study. You reported symptoms of a concussion in the most recent weekly surveillance report. Is that correct?

If no: review responses from weekly surveillance report.

If yes: *We'd like to get more information about the injury. Is now a good time to talk?*

If no, please call back at _____.

Question 1.

When did your (your child's) injury occur?

Date of Concussion and day of the week: _____

Date of 1st practice/game after concussion and day of the week: _____

We would like to get a bit more information about your (your child's) injury.

Question 2.

Please describe how the injury happened:

Question 3.

What were you (was your child) doing at the time of the injury? Report most appropriate answer.

- 1 Shooting (foot)
- 2 Passing (foot)
- 3 Receiving pass
- 4 Kicking
- 5 Dribbling
- 6 Defending
- 7 Blocking Shot
- 8 Chasing Loose Ball
- 9 Heading Ball
- 10 Attempting a slide tackle
- 11 Receiving a slide tackle
- 12 Goaltending
- 13 Conditioning/stretching
- 14 Running
- 15 Jumping
- 16 Not moving
- 17 Trying to get the ball from opponent
- 18 Other (please specify) _____

Question 4.

Were you (was your child) trying to head the ball when you (they) had a collision?

- 1 No
- 2 Yes

Question 5.

Describe exactly where the hit occurred – in the head or body.

- 1 Head→
 - a. Face
 - b. Top of head
 - c. Right side of head
 - d. Left side of head
 - e. Back of head
- 2 Body

Question 6.

Did the injury happen in a practice or game?

- 1 Practice
- 2 Game

*Ask question 7 only if s/he was playing **in a game** at the time of injury.*

Question 7.

What field position were you (was your child) playing at the time of the injury?

- 1 Defender
- 2 Forward
- 3 Midfielder
- 4 Goalie

Question 8.

What did you (your child) collide with?

- 1 Another person
 - a Head to head
 - b Head to arm
 - c Head to leg
- 2 Playing surface (e.g. ground, field, etc)
- 3 Goal post
- 4 Out of bounds object (e.g. wall, fence, etc)
- 5 Other (please specify) _____

Question 9.

I am going to read you some symptoms that might have occurred after being hit. For each symptom, first let me know how severe each symptom was on the day you were (your child was) hit, using numbers 0 to 6. 0 means you did not have this symptom and 6 means your symptom was severe.

	None	Mild		Moderate		Severe		
Headache	0	1	2	3	4	5	6	
"Pressure in head"	0	1	2	3	4	5	6	
Nausea or vomiting	0	1	2	3	4	5	6	
Dizziness	0	1	2	3	4	5	6	
Blurred vision	0	1	2	3	4	5	6	
Balance problems	0	1	2	3	4	5	6	
Sensitivity to light	0	1	2	3	4	5	6	
Sensitivity to noise	0	1	2	3	4	5	6	
Feeling slowed down	0	1	2	3	4	5	6	
Feeling like "in a fog"	0	1	2	3	4	5	6	
"Don't feel right"	0	1	2	3	4	5	6	
Difficulty concentrating	0	1	2	3	4	5	6	
Difficulty remembering	0	1	2	3	4	5	6	
Fatigue or low energy	0	1	2	3	4	5	6	
Confusion	0	1	2	3	4	5	6	
Drowsiness	0	1	2	3	4	5	6	
Trouble falling asleep	0	1	2	3	4	5	6	
More emotional	0	1	2	3	4	5	6	
Irritability	0	1	2	3	4	5	6	
Sadness	0	1	2	3	4	5	6	
Nervous or anxious	0	1	2	3	4	5	6	
Loss of consciousness (Passed out)	No		Yes					

If athlete answers all "0", then not eligible as concussion case and terminate interview.

Question 10.

Now, I am going to read you the same symptoms. For each symptom, let me know how severe each symptom was in the last 24 hours, using numbers 0 to 6. 0 means you did not have this symptom and 6 means your symptom is severe.

	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or anxious	0	1	2	3	4	5	6
Loss of consciousness (Passed out)	No		Yes				

Question 11.

How long did you (your child) have these symptoms?

- 1 ≤ 15 minutes
- 2 > 15 minutes but ≤ 1 hour
- 3 > 1 hour but ≤ 1 day
- 4 > 1 day but ≤ 3 days
- 5 > 3 days but ≤ 1 week
- 6 Still having symptoms

Question 12.

Did you (your child) keep playing for the remainder of the game or practice after sustaining the hit or did you (your child) stop playing before the end of the game or practice?

- 1 Played the remainder of the game or practice:
 - a ≤ 5 minutes
 - b > 5 minutes but ≤ 30 minutes
 - c > 30 minutes
- 2 Stopped playing before the end of game or practice:
 - a ≤ 5 minutes
 - b > 30 minutes but ≤ 30 minutes
 - c > 30 minutes

Question 13.

If you (your child) stopped playing, what made you (them) stop playing?

- 1 Didn't feel well so asked to sub out.
- 2 Coach noticed not playing well and took me (them) out.
- 3 Carried off the field.
- 4 Couldn't play (couldn't run, couldn't see)
- 5 Pulled by athletic trainer or other medical personnel.
- 6 Other (describe)_____

Question 14.

Did you (your child) tell any of the following people about your (your child's) hit and symptoms or did they otherwise know ? (Choose all that apply).

- 1 Coach
 - a. Told
 - b. Already knew
- 2 Parent
 - a. Told
 - b. Already knew
- 3 Doctor, nurse or other health provider
 - a. Told
 - b. Already knew
- 4 Athletic trainer
 - a. Told
 - b. Already knew
- 5 Friend or teammate
 - a. Told
 - b. Already knew
- 6 No one

Question 15.

Did you (your child) see a health care provider for your symptoms (doctor, nurse, nurse practitioner, physician's assistant or certified athletic trainer)?

- 1 No → go to Q19
- 2 Yes

Question 16.

For each health care provider, ask:

Provider 1

Type of provider (1=MD, 2=NP, 3=PA, 4=ATC, 5=other)

Date saw the health care provider ___/___/___

Did the provider give you (your child) a diagnosis?

- 1 No
- 2 Yes, please write the diagnosis here: _____

Provider 2

Type of provider (1=MD, 2= NP, 3=PA, 4=ATC, 5=other)

Date saw the health care provider ___/___/___

Did the provider give you (your child) a diagnosis?

- 1 No
- 2 Yes, please write the diagnosis here: _____

Question 17.

Did you (your child) get any instructions from the health care provider on when to return to playing soccer?

- 1 No
- 2 Yes→

- A. Return to play once symptoms resolve.
- B. Return to play gradually once symptoms resolve, restrict activities if symptoms develop.
- C. Return to play gradually once symptoms resolve, push through if symptoms develop.
- D. Return to play in a specific time period (such as 1 week, 2 weeks, or 1 month), regardless of symptoms.
- E. Other _____

Q 17a.

Did your (your child's) health care provider recommend restricting media use (television, computer, texting)?

- 1 No
- 2 Yes

Q 17b.

Did your (your child's) health care provider recommend restricting homework and mental activity?

- 1 No
- 2 Yes

Q 17c.

Did your (your child's) health care provider recommend restricting physical activity?

- 1 No
- 2 Yes

Q 17d.

Did your (your child's) health care provider provide a note clearing you (them) return to soccer?

- 1 No
- 2 Yes

Question 18.

Are you (your child) still experiencing concussive symptoms?

- 1 Yes
- 2 No → When did these resolve? _____ / _____ / _____

Question 19.

Did you (your child) play soccer or exercise while experiencing concussive symptoms?

Choose one.

- 1 Did not do any activity while experiencing concussive symptoms
- 2 Exercised while experiencing concussive symptoms, but did not play soccer
- 3 Attended practice while experiencing concussive symptoms, but did not play a game
- 4 Played a game while experiencing concussive symptoms
- 5 Played a tournament while experiencing concussive symptoms

Question 20:

Have you (your child) returned to play with your (their) club soccer team? *Choose one.*

- 1 Yes, playing normally
- 2 Yes, but only practicing, not playing games
- 3 No, not playing due to concussion
- 4 No, not playing for another reason
- 5 Other _____

Question 21.

Do you have any additional comments or questions?

If athlete is playing normally...

Since you're back to playing normally, this is the only interview we'll be doing. We hope the season goes well. We may be calling you in the future to ask questions like these again. Thanks for making the time to talk with us.

If athlete is not playing normally...

We'll call you next week to see how you're doing and ask some of these questions again....when is a good time to reach you? Thanks for making the time to talk with us.

Day _____

Time _____

Phone number to call _____

Interviewer Questions:

1. How cooperative was the respondent?

- a. Very
- b. Somewhat
- c. Not very
- d. Somewhat hostile
- e. Very hostile

2. Did you feel the subject understood the questions?

- a. Yes, understood fully
- b. Understood most
- c. Understood little
- d. Understood very little

Additional interviewer comments:
