Symptom Checklist

Name

Date

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Concussion: | | | | | | | | Total |
| Headache | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Nausea | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Vomiting | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Balance Problems | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Dizziness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Fatigue | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Trouble Falling Asleep | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Sleeping More Than Usual | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Sleeping Less Than Usual | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Drowsiness | 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 |  |
| Irritability | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Sadness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Nervousness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Feeling More Emotional | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Numbness and Tingling | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Feeling Slowed Down | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Feeling Mentally “Foggy” | 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 |  |
| Visual Problems | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Neck Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Confusion | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| “Don’t feel right” | 0 | 1 | 2 | 3 | 4 | 5 | 6 |  |
| Overall Symptom Score | | | | | | | |  |