

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

Symptom	None	Mild	Moderate	Severe			
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 PROBLEM/ DIZZINESS	0	1	2	3	4	5	6
FATIGUE	0	1	2	3	4	5	6
SKIN RASH/ ITCHING	0	1	2	3	4	5	6
TROUBLE SLEEPING	0	1	2	3	4	5	6
SLEEPING MORE 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
BLURRED VISION	0	1	2	3	4	5	6
SENSITIVITY TO NOISE	0	1	2	3	4	5	6
JOINT STIFFNESS (FINGERS)	0	1	2	3	4	5	6
SADNESS	0	1	2	3	4	5	6
IRRITABILITY	0	1	2	3	4	5	6
NUMBNESS/ TINGLING	0	1	2	3	4	5	6
FEELING LIKE "IN A FOG"	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
NECK PAIN	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>
Column Total Score (add #s)	—	—	—	—	—	—	—

Total # of Items Endorsed: \_\_\_\_\_

Overall Total Score: \_\_\_\_\_

Assuming you were at 100% before your concussion, give a percentage rate to your current overall condition: \_\_\_\_\_%