Post-Concussion Symptom CHECKLIST

Name: Date:	Name:	e:	Date:	//		_
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Instructions: For each item please indicate how much the symptom has bothered you over the *past 2 days*

Symptoms		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	0	1	2	3	4	5	6
- Je	Dizziness	0	1	2	3	4	5	6
Physica	Visual Problems	0	1	2	3	4	5	6
P	Fatigue	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
	Numbness/Tingling	0	1	2	3	4	5	6
	Pain other than Headache	0	1	2	3	4	5	6
bū	Feeling Mentally Foggy	0	1	2	3	4	5	6
king	Feeling Slowed Down	0	1	2	3	4	5	6
Thinking	Difficulty Concentrating	0	1	2	3	4	5	6
	Difficulty Remembering	0	1	2	3	4	5	6
	Drowsiness	0	1	2	3	4	5	6
Sleep	Sleeping Less than Usual	0	1	2	3	4	5	6
Sle	Sleeping More than Usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
а	Irritability	0	1	2	3	4	5	6
Emotional	Sadness	0	1	2	3	4	5	6
l å	Nervousness	0	1	2	3	4	5	6
Ū	Feeling More Emotional	0	1	2	3	4	5	6

Exertion	Do these symptoms wors	en with:							
	Physical Activity	Yes	O No	O Not ap	plicable	j			
	Thinking/Cognitive Activ	rity O Yes	O No	O Not ap	plicable	5			
Overall F	Rating: How different is the	e person act	ing com	pared to l	his/her	usual s	elf?		
	Same as Usual 0	1	2	3 4	5		6	Very Differe	nt؛
Activity	Level: Over the past two d	ays, compar	ed to w	hat I woul	d typica	lly do,	my leve	el of activity	has
	been % of w	hat it would	be nori	mally.					