**Concussion Symptom Checklist**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_

Sex: Male /Female /Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you lose consciousness? \_\_\_\_\_\_\_\_\_\_\_\_

How did you get your suspected concussion? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date/time of injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many diagnosed concussions have you had in the past? \_\_\_\_\_\_\_\_\_\_\_

When was the most recent concussion before this injury? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been (check all that apply)?**

diagnosed / treated for a headache disorder or migraines

diagnosed with a learning disability/dyslexia

diagnosed with ADD/ADHD

diagnosed with depression or anxiety

List all current medications, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please rate the severity of your symptoms from 0 (no symptoms) to 6 (severe symptoms) by circling the appropriate number for each symptom below:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **0** | **1** | **2** | **3** | **4** | **5** | **6** | | **no symptoms** | **mild symptoms** | | **moderate symptoms** | | **severe symptoms** | | | |
| **Emotional** | |
| 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 |
| **Sleep** | |
| Drowsiness | 0 1 2 3 4 5 6 |
| Changes in sleep patterns | 0 1 2 3 4 5 6 |
| **Exertion** | |
| Symptoms get worse with mental activity | 0 1 2 3 4 5 6 |
| Symptoms get worse with physical activity | 0 1 2 3 4 5 6 |

|  |  |
| --- | --- |
| **Physical** | |
| Headache | 0 1 2 3 4 5 6 |
| “Pressure in head” | 0 1 2 3 4 5 6 |
| Neck pain | 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 |
| Visual problems | 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 |
| Fatigue or low energy | 0 1 2 3 4 5 6 |
| Difficulty remembering | 0 1 2 3 4 5 6 |
| **Cognitive** | |
| Difficulty concentrating or remembering | 0 1 2 3 4 5 6 |
| Feeling mentally foggy | 0 1 2 3 4 5 6 |
| Confusion | 0 1 2 3 4 5 6 |
| Feeling slowed down | 0 1 2 3 4 5 6 |