



Athlete: _____ Grad Yr: _____

Concussion Symptom Scale

Symptoms

Rate your symptoms using this scale:
 0 None 1 Mild 2 Moderate 3 Severe 4 5 6

Symptoms	Date:	Date:	Date:	Date:	Date:	Date:
Headache						
Pressure in head						
Neck pain						
Nausea or vomiting						
Dizziness (spinning or movement sensation)						
Blurred vision						
Balance problems						
Sensitivity to light						
Sensitivity to noise						
Feeling slowed down						
Feeling like "in a fog"						
"Don't feel right"						
Difficulty concentrating						
Difficulty remembering						
Fatigue or low energy						
Confusion						
Drowsiness						
Trouble falling asleep						
Tinnitus						
Irritability						
Sadness						
Nervous or anxious						
Daily Total						
Are these symptoms tolerable?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Do they worsen with mental activity?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
If so, how long can you tolerate mental activities?	mins	mins	mins	mins	mins	mins
Do they worsen with physical activity?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Are you having any trouble in your classes?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
If so, what kind of trouble & in which classes?						