Name: _____ **Date:** _____

Age/DOB: _____ Date of Injury: _____

Post-Concussion Symptom Scale

No symptoms	Mild	Moderate	Severe
0	1 -- 2	3 -- 4	5 --6

SYMPTOMS

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 to sleep	0 - 1 - 2 - 3 - 4 - 5 - 6
Excessive sleep	0 - 1 - 2 - 3 - 4 - 5 - 6
Loss of sleep	0 - 1 - 2 - 3 - 4 - 5 - 6
Drowsiness	0 - 1 - 2 - 3 - 4 - 5 - 6
Light sensitivity	0 - 1 - 2 - 3 - 4 - 5 - 6
Noise sensitivity	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
More emotional	0 - 1 - 2 - 3 - 4 - 5 - 6
Numbness	0 - 1 - 2 - 3 - 4 - 5 - 6
Feeling "slow"	0 - 1 - 2 - 3 - 4 - 5 - 6
Feeling "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

TOTAL SYMPTOMS: _____/22 ____% TOTAL SCORE: _____/132 ___%

ADDITIONAL SYMPTOMS (Post-Concussion Symptom Assessment)

Neck Pain	0 - 1 - 2 - 3 - 4 - 5 - 6
Confusion	0 - 1 - 2 - 3 - 4 - 5 - 6
Frustration	0 - 1 - 2 - 3 - 4 - 5 - 6
Taking longer to think	0 - 1 - 2 - 3 - 4 - 5 - 6
Restlessness	0 - 1 - 2 - 3 - 4 - 5 - 6
"Don't feel right"	0 - 1 - 2 - 3 - 4 - 5 - 6
Blurred Vision	0 - 1 - 2 - 3 - 4 - 5 - 6
Double Vision	0 - 1 - 2 - 3 - 4 - 5 - 6

TOTAL SYMPTOMS: _____/30 ____% TOTAL SCORE: _____/180 ___%