EL DORADO HILLS
SPORTS MEDICINE

(office use) Medical Record # ___________________

CONCUSSION SYMPTOMS CHECKLIST

Patient name: _______________________________ **Date of Birth:**_____________ **Age:**__________

Today's date:________________ **Date of injury:**_________________

Please rate how much the following symptoms bother you/athlete today, or in the past day:

	None	Mild		Moderate		Severe	
PHYSICAL (10)							
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
Visual problems	0	1	2	3	4	5	6
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
COGNITIVE (4)							
Feeling mentally foggy	0	1	2	3	4	5	6
Feeling slowed down	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
EMOTIONAL (4)							
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6
SLEEP (4)							
Drowsiness	0	1	2	3	4	5	6
Sleeping less than usual	0	1	2	3	4	5	6
Sleeping more than usua	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
TOTALS							
	Total number of symptoms present						
	Total score of symptoms						