USA SOFTBALL™
of Southern California

Graded Concussion Symptom Checklist

Today's Date: ____________ Time:_____________ Hours of Sleep:_____________ Date of Diagnosis:______________

☐ **Baseline Score**
☐ **Post-Concussion Score**

- **Grade the 22 symptoms with a score of 0 through 6.**
  - Note that these symptoms may not all be related to a concussion.
- **You can fill this out at the beginning of the season as a baseline** (after a good night's sleep)
- **If you suffer a suspected concussion, use this checklist to record your symptoms daily.**
  - Be consistent and try to grade either at the beginning or end of each day.
- **There is no scale to compare your total score to; the checklist helps you follow your symptoms on a day-to-day basis.**
  - If your total scores are not decreasing, see your physician right away.
- **Show your baseline (if available) and daily checklists to your physician.**

	None	**Mild**		**Moderate**			**Severe**
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
Blurred Vision	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
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	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
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
More emotional than usual	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
Total Sum of Each Column	0						
Total Symptom Score (Sum of all column totals)							

Athlete's Name:___________________________________ League/Team:____

D.O.B.______________________ Physician (MD/DO) ___________________________________Date:___________________