

Graded Concussion Symptom Checklist

Today's Date: _____ Time: _____ Hours of Sleep: _____ Date of Diagnosis: _____

- **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.**

<input type="checkbox"/> Baseline Score
<input type="checkbox"/> Post-Concussion Score

	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: _____