ImPACT APPLICATIONS, INC.

ConcussionManagement.com

Post-Concussion Symptom Scale

Patient's Name: _____

Date of Birth: _____

Please use the following scale to rate each symptom:

None	Mild		Moderate			Severe
0	1	2	3	4	5	6

SYMPTOMS	SEVERITY RATING						
	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Headache							
Nausea							
Vomiting							
Balance Problems							
Dizziness (spinning or movement sensation)							
Lightheadedness							
Fatigue							
Trouble falling asleep							
Sleeping more than usual							
Sleeping less than usual							
Drowsiness							
Sensitivity to light							
Sensitivity to noise							
Irritability							
Sadness							
Nervous/ Anxious							
Feeling more emotional							
Numbness or tingling							
Feeling slowed down							
Feeling like "in a fog"							
Difficulty concentrating							
Difficulty remembering							
Visual problems							
Other							
Total							