» Symptom Checklist

Name: _____ Assessment Date: _____

Date of Injury: _____ Time of Injury 2-3 Hrs 24 Hrs 48 Hrs 72 Hrs Daily Weekly

Symptoms	Severity Rating						
		Mild	Mild	Moderate	Moderate	Severe	Severe
I feel like I'm going to faint	0	1	2	3	4	5	6
I'm having trouble balancing	0	1	2	3	4	5	6
I feel dizzy	0	1	2	3	4	5	6
It feels like the room is spinning	0	1	2	3	4	5	6
Things look blurry	0	1	2	3	4	5	6
I see double	0	1	2	3	4	5	6
I have headaches	0	1	2	3	4	5	6
I feel sick to my stomach (nauseated)	0	1	2	3	4	5	6
Noise/sound bothers me	0	1	2	3	4	5	6
The light bothers my eyes	0	1	2	3	4	5	6
I have pressure in my head	0	1	2	3	4	5	6
I feel numbness and tingling	0	1	2	3	4	5	6
I have neck pain	0	1	2	3	4	5	6
I have trouble falling asleep	0	1	2	3	4	5	6
I feel like sleeping too much	0	1	2	3	4	5	6
I feel like I am not getting enough sleep	0	1	2	3	4	5	6
I have low energy (fatigue)	0	1	2	3	4	5	6
I feel tired a lot (drowsiness)	0	1	2	3	4	5	6
I have trouble paying attention	0	1	2	3	4	5	6
I am easily distracted	0	1	2	3	4	5	6
I have trouble concentrating	0	1	2	3	4	5	6
I have trouble remembering things	0	1	2	3	4	5	6
I have trouble following directions	0	1	2	3	4	5	6
I feel like my thinking is "foggy"	0	1	2	3	4	5	6
I feel like I am moving at a slower speed	0	1	2	3	4	5	6
I don't feel "right"	0	1	2	3	4	5	6
I feel confused	0	1	2	3	4	5	6
I have trouble learning new things	0	1	2	3	4	5	6
I feel more emotional	0	1	2	3	4	5	6
I feel sad	0	1	2	3	4	5	6
I feel nervous	0	1	2	3	4	5	6
I feel irritable or grouchy	0	1	2	3	4	5	6

Other: _____

Weekly symptom progress monitoring is recommended as best practice.