

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Self-Reported Rating of Concussion Symptoms

Please rate each of the following symptoms by circling the best answer on the 0-6 scale for up to past 2 weeks

1 = minor, 2 = annoying, 3 = moderate, 4 = significant, 5 = intense and disruptive, 6 = worst and unbearable

Symptom	Frequency								*	Intensity							
	None	Mild		Moderate		Severe		Mild		Moderate		Severe					
		1-25%		25-50%		>50%	100%		1	2	3	4	5	6			
Headache	0	1	2	3	4	5	6	*	1	2	3	4	5	6			
Nausea	0	1	2	3	4	5	6		1	2	3	4	5	6			
Vomiting	0	1	2	3	4	5	6		1	2	3	4	5	6			
Balance problems	0	1	2	3	4	5	6		1	2	3	4	5	6			
Dizziness	0	1	2	3	4	5	6	*	1	2	3	4	5	6			
Blurred or double vision	0	1	2	3	4	5	6		1	2	3	4	5	6			
Fatigue or low energy	0	1	2	3	4	5	6	*	1	2	3	4	5	6			
Sensitivity to light	0	1	2	3	4	5	6		1	2	3	4	5	6			
Sensitivity to noise	0	1	2	3	4	5	6		1	2	3	4	5	6			
Numbness/Tingling	0	1	2	3	4	5	6		1	2	3	4	5	6			
Ringing in Ears	0	1	2	3	4	5	6		1	2	3	4	5	6			
Feeling like "in a fog"	0	1	2	3	4	5	6		1	2	3	4	5	6			
Confusion	0	1	2	3	4	5	6		1	2	3	4	5	6			
Feeling slowed down	0	1	2	3	4	5	6		1	2	3	4	5	6			
Difficulty concentrating	0	1	2	3	4	5	6	*	1	2	3	4	5	6			
Difficulty remembering	0	1	2	3	4	5	6	*	1	2	3	4	5	6			
Spontaneous laugh or cry	0	1	2	3	4	5	6		1	2	3	4	5	6			
Irritability	0	1	2	3	4	5	6	*	1	2	3	4	5	6			
Sadness or Depression	0	1	2	3	4	5	6		1	2	3	4	5	6			
Nervousness or Anxiety	0	1	2	3	4	5	6		1	2	3	4	5	6			
Drowsiness during the day	0	1	2	3	4	5	6		1	2	3	4	5	6			
Sleeping less than usual	0	1	2	3	4	5	6	*	1	2	3	4	5	6			
Sleeping more than usual	0	1	2	3	4	5	6	*	1	2	3	4	5	6			
Trouble falling asleep	0	1	2	3	4	5	6	*	1	2	3	4	5	6			
Reduced tolerance to stress, emotions or alcohol	0	1	2	3	4	5	6	*	1	2	3	4	5	6			

Meets diagnostic criteria F07.81 YES NO

Symptom Frequency: \_\_\_\_/150, Symptom Intensity: \_\_\_\_/150, Composite (add F & I/3): \_\_\_\_%