

# SYMPTOM SCALE



COLORADO  
CONCUSSION  
CLINIC

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

Score yourself on the duration of the following symptoms throughout the **PAST 24 HOURS**

		Mild (Briefly)	Moderate (Sometimes)	Severe (Always)			
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/vomiting	0	1	2	3	4	5	6
Dizziness/Lightheaded	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Numbness/tingling	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Ringing in ears	0	1	2	3	4	5	6
Sensitive to light	0	1	2	3	4	5	6
Sensitive 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/low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Inability to Multitask	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
Trouble staying asleep	0	1	2	3	4	5	6
Sleeping more	0	1	2	3	4	5	6
Sleeping less/insomnia	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritable	0	1	2	3	4	5	6
Sadness/Depression	0	1	2	3	4	5	6
Nervous/anxious	0	1	2	3	4	5	6
							<b>TOTAL SCORE: _____</b>

1700 East 17th Ave., Suite 102 Denver, CO 80218

Phone:303-932-2030

info@healmyconcussion.com

Fax:833-380-1476

Revised 2018-10-26