Post-Concussion Symptom Scale

Name:_____ Date: _____

Instructions: For each item indicate how much the symptom has bothered you ***in the last 72 hours***

	Symptoms	none	mild		moderate		severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Visual Problems	0	1	2	3	4	5	6
	Fatigue	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
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling Mentally Foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping Less than Usual	0	1	2	3	4	5	6
	Sleeping More than Usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotional	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more Emotional	0	1	2	3	4	5	6
Pain other than Headache		0	1	2	3	4	5	6

Exertion: Do these symptoms worsen with:

Physical Activity ☐Yes ☐No ☐ not applicable

Thinking/School/Cognitive Activity ☐Yes ☐No ☐ not applicable

Over the past two days, my daily activity level is _____% of normal.

If your symptoms persist past 4 weeks, please contact your Physician or a Neuropsychologist for further evaluation.

Post-Concussion Symptom list©2013 v2.0
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