POST CONCUSSION SYMPTOM CHECKLIST

Player Name: _____ Date: _____

Team: _____ Age:_____ Previous Head Injury:__Y / N

Time of Concussion: _____

Describe Incident: _____

_____

_____

Directions: The objective of this worksheet is to record information for later use by a medical professional. It is not intended to diagnose the player.

For each symptom, please use a number scale from 0-6 to describes the way the player is feeling. A rating of 0 means the player is not experiencing the symptom. If the symptom is being experienced, the 1 rating is the mildest and the 6 rating is the most severe.

The 2nd through fourth columns are for the coach or parent to administer. All this information will be valuable information when the player is able to see a medical practitioner.

Symptom	Time of Injury 0 1 2 3 4 5 6	2-3 Hours Post Injury 0 1 2 3 4 5 6	24 Hours Post Injury 0 1 2 3 4 5 6	48 Hours Post Injury 0 1 2 3 4 5 6	72 Hours Post Injury 0 1 2 3 4 5 6
Headache					
"Pressure in head"					
Neck Pain					
Nausea or Vomiting					
Dizziness					
Blurred Vision					
Balance Problems					
Sensitivity to Light					
Sensitivity to Noise					
Feeling Slowed Down					
Feeling like "in a fog"					
"Don't feel right"					
Difficulty Concentrating					
Difficulty Remembering					
Fatigue or Low Energy					
Confusion					
Drowsiness					
Trouble Falling Asleep					
More emotional					
Irritability					
Sadness					
Nervous or Anxious					

(**Question to ask the student athlete:**)

Was there a loss of consciousness or unresponsiveness? Y N If so, how long? _____Minutes

If you know the athlete well prior to the injury, how different is the athlete acting compared to his/her usual self?

no different very different unsure