# Post-Concussion Symptom Scale

**Patient’s Name:** __________________________________________

**Date of Birth:** __________________

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Please use the following scale to rate each symptom:

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Date:</td>
<td>Date:</td>
<td>Date:</td>
<td>Date:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

- Headache
- Nausea
- Vomiting
- Balance Problems
- Dizziness (spinning or movement sensation)
- Lightheadedness
- Fatigue
- Trouble falling asleep
- Sleeping more than usual
- Sleeping less than usual
- Drowsiness
- Sensitivity to light
- Sensitivity to noise
- Irritability
- Sadness
- Nervous/Anxious
- Feeling more emotional
- Numbness or tingling
- Feeling slowed down
- Feeling like "in a fog"
- Difficulty concentrating
- Difficulty remembering
- Visual problems
- Other

<table>
<thead>
<tr>
<th><strong>Total</strong></th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
</table>

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