Appendix A
Concussion Symptom Score Checklist

Athlete Name: _____ Date of Injury: _____

Rate the severity of each symptom on a scale of 0-6. 0 indicates you are not currently
experiencing that symptom. 1 = Mild; 3 = Moderate; 6 = Severe.

Symptom	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Blurred Vision							
Dizziness							
Drowsiness							
Excess Sleep							
Easily Distracted							
Fatigue							
Feel "in a fog"							
Feel "slowed down"							
Headache							
Inappropriate emotions							
Irritability							
Loss of consciousness							
Loss of orientation							
Memory Problems							
Nausea							
Nervousness							
Personality Change							
Poor balance/coordination							
Poor concentration							
Ringing in ears							
Sadness							
Seeing stars							
Sensitivity to Light							
Sensitivity to Noise							
Sleep Disturbance							
Vacant stare/glassy eyed							
Vomiting							