ST. THOMAS AQUINAS HIGH SCHOOL

Concussion – Daily Symptom Sheet

Name:_____ Date: _____

Date of Injury: _____ Daily %: _____ Score: _____

	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 (blurred or double)	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
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervous	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

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