ACNC Concussion Symptom Score Sheet

If you are unsure of a question or do not feel well enough to complete this form you may leave it blank and ask for assistance from one of our staff members. Thank you

Name: _____ DOB: _____ Date of Injury: _____ Today's Date: _____

(0=No Symptoms) (1-2=Very Mild) (3-4=Mild) (5-6=Moderate) (7-8=Severe) (9-10=Worst Ever)

Please circle the number that best matches the way you feel right now.

Headache:	0	1	2	3	4	5	6	7	8	9	10
Nausea:	0	1	2	3	4	5	6	7	8	9	10
Vomitting:	0	1	2	3	4	5	6	7	8	9	10
Balance Problems:	0	1	2	3	4	5	6	7	8	9	10
Dizziness:	0	1	2	3	4	5	6	7	8	9	10
Fatigue/Drowsiness:	0	1	2	3	4	5	6	7	8	9	10
Trouble Falling Asleep:	0	1	2	3	4	5	6	7	8	9	10
Needing More Sleep:	0	1	2	3	4	5	6	7	8	9	10
Sensitivity to Light:	0	1	2	3	4	5	6	7	8	9	10
Sensitivity to Noise:	0	1	2	3	4	5	6	7	8	9	10
Irritability:	0	1	2	3	4	5	6	7	8	9	10
Sadness:	0	1	2	3	4	5	6	7	8	9	10
Nervousness:	0	1	2	3	4	5	6	7	8	9	10
Feeling Emotional:	0	1	2	3	4	5	6	7	8	9	10
Numbness or Tingling:	0	1	2	3	4	5	6	7	8	9	10
Feeling Slowed Down:	0	1	2	3	4	5	6	7	8	9	10
Feeling Mentally Foggy:	0	1	2	3	4	5	6	7	8	9	10
Trouble Concentrating:	0	1	2	3	4	5	6	7	8	9	10
Memory Issues:	0	1	2	3	4	5	6	7	8	9	10
Visual Problems:	0	1	2	3	4	5	6	7	8	9	10