**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 |

Name_____

Date_____ Date of Injury _____

***Concussion Questionnaire***

Please answer the following questions in good detail:

***Have you ever had from MONO, STREP, MOLD EXPOSURE, LYME, AUTOIMMUNITY?*** *(Circle all that apply)*

***Specifically, what symptoms or stressful situations were going on BEFORE, DURING, and IMMEDIATELY FOLLOWING your concussion?***

*(examples- I was going through a divorce, then I got a 24 hour gut bug, I was under immense amounts of stress at work/school, I was dealing with IBS, constipation/diarrhea, anxiety/depression, and autoimmune condition, diabetes, type A personality, I was on day 20 of my menstrual cycle)*

***BEFORE***

***DURING***

***IMMEDIATELY FOLLOWING***