IN-OFFICE CONCUSSION SYMPTOM SCORE

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 the medical assistant when you are called back. Thank you.

Name: ________________________________ **D.O.B.** ___________ **Today's Date:** ___________ **DOI:** ____________

(**1** = Very Mild) (**2** = Mild) (**3** = Moderate) (**4** = Worse) (**5** = Severe) (**6** = Worst Ever)

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

Example:	0	1	(2)	3	4	5	6

1) Headache	0	1	2	3	4	5	6
2) Nausea	0	1	2	3	4	5	6
3) Vomiting	0	1	2	3	4	5	6
4) Balance Problems	0	1	2	3	4	5	6
5) Dizziness	0	1	2	3	4	5	6
6) Fatigue	0	1	2	3	4	5	6
7) Trouble falling asleep	0	1	2	3	4	5	6
8) Sleeping more than usual	0	1	2	3	4	5	6
9) Sleeping less than usual	0	1	2	3	4	5	6

00-0709
(04/2015)

Banner Health®

IN-OFFICE CONCUSSION SYMPTOM SCORE

Name: ______________________________ **D.O.B.:** ____________________

10) Drowsiness	0	1	2	3	4	5	6
11) Sensitivity to light	0	1	2	3	4	5	6
12) Sensitivity to noise	0	1	2	3	4	5	6
13) Irritability	0	1	2	3	4	5	6
14) Sadness	0	1	2	3	4	5	6
15) Nervousness	0	1	2	3	4	5	6
16) Feeling more emotional	0	1	2	3	4	5	6
17) Numbness or tingling	0	1	2	3	4	5	6
18) Feeling slowed down	0	1	2	3	4	5	6
19) Feeling mentally foggy	0	1	2	3	4	5	6
20) Difficulty concentrating	0	1	2	3	4	5	6
21) Difficulty remembering	0	1	2	3	4	5	6
22) Visual problems	0	1	2	3	4	5	6

Total: ______________ (Physician use only)

00-0709
(04/2015)