Date of Injury:_____

Concussion Symptoms Progress Journal

Name:_____ Date of Journal entry:_____

Each day complete the following:

1. Rate symptoms on chart below according to following scale;

None: 0 **Mild: 1-2** **Moderate: 3-4** **Severe: 5-6**

Physical Changes	Rate 1-6	Behavioral Changes	Rate 1-6	Cognitive Changes	Rate 1-6	Sleep Changes	Rate 1-6
Headache		Irritable		Fogginess		Fragmented Sleep	
Nausea		More Emotional		Confusion			
Dizziness		Confused		Amnesia			
Sensitivity to Light		Depression		Difficulty Focusing		Difficulty Falling Asleep	
Fatigue		Moody		Easily distracted			
Balance Problems		Combative		Difficulty Concentrating		Sleeping more than normal	
Vomiting		Disorientation		Confused on time and place		Sleeping less than normal	
Loss of Consciousness				Difficulty Remembering			
Ringing in ears				Delayed response			
Sensitivity to Sound				Language/ speech comprehension issues			

2. **Sleep, Nutrition and Hydration**:

Hours of continuous sleep:_____

Hours spent napping:_____

Hours of TV, Computer or Video Games:_____

Amount of water consumed:_____cups

Rate your nutritional intake: **very good** **good** **slightly poor** **poor**

3. **Academic Work**:

Time spent on school work: **20min-1hr** **1hr-2hr** **2hr-3hr** **3hr-4hr** **4hr-plus**

Additional Comments:

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