

MPS ATHLETIC DEPARTMENT

#mpspride



Current Concussion Symptoms and Conditions

Student's Name: _____ Date: _____

Sport: _____ School: _____

Date of Last Concussion: _____ (month - day - year)

Total Hours of Sleep Last Night: _____ Current Medications: _____

Circle the number below that indicates the degree to which you are CURRENTLY experiencing the following symptoms:

	<u>No Symptoms = 0</u>			<u>Moderate = 3</u>			<u>Severe = 6</u>
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
Fatigue	0	1	2	3	4	5	6
Trouble Falling Asleep	0	1	2	3	4	5	6
Excessive Sleep	0	1	2	3	4	5	6
Loss of Sleep	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Light Sensitivity	0	1	2	3	4	5	6
Noise Sensitivity	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6
More Emotional	0	1	2	3	4	5	6
Numbness	0	1	2	3	4	5	6
Feeling "foggy"	0	1	2	3	4	5	6
Feeling "slow"	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
Visual Problems	0	1	2	3	4	5	6

Total Symptoms 0x_ 1x_ 2x_ 3x_ 4x_ 5x_ 6x_

Total Symptom Score = ____ (this score doesn't indicate the severity of a concussion, only the severity of the current symptoms)