



CIF GRADED CONCUSSION SYMPTOM CHECKLIST



Today's Date: _____ Time: _____ Hours of Sleep: _____ Date of Injury: _____ Date of Diagnosis: _____

- **Grade the 22 symptoms with a score of 0 through 6.**
 - *Note that these symptoms may not all be related to a concussion.*
- **You can fill this out at the beginning of the season as a baseline (after a good night's sleep).**
- **If you suspect that you have a concussion, use this checklist to record your symptoms.**
- **You can track your symptoms as you recover.**
 - *There is no scale to which to compare your total score; your score is individualized to you.*
- **Show your baseline (if available) and any follow-up checklists to your physician.**

- Baseline Score**
- Post Concussion Score**

	None	Mild	Moderate	Severe			
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or Vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred Vision	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	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
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
More emotional than usual	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6
TOTAL SUM OF EACH COLUMN	0						
TOTAL SYMPTOM SCORE (Sum of all column totals)							

NAME _____ HIGH SCHOOL _____

D.O.B. _____ SPORT _____ PHYSICIAN (MD/DO) _____