PRINCETON SPORTS & FAMILY MEDICINE

Patient Name: _____ D.O.B. _____

Today's Date: _____ Date of Injury: _____

Concussion/Head Trauma Symptoms

0 = None 6 = Severe (Symptoms as of Today)

Headache		0	1	2	3	4	5	6	
Pressure		0	1	2	3	4	5	6	
Neck Pain		0	1	2	3	4	5	6	
Balance Problems/ Dizziness		0	1	2	3	4	5	6	
Nausea/Vomiting		0	1	2	3	4	5	6	
Vision Problems		0	1	2	3	4	5	6	
Ringing in the Ear/ Hearing Problems		0	1	2	3	4	5	6	
"Don't Feel Right"		0	1	2	3	4	5	6	
Feeling "Dazed"		0	1	2	3	4	5	6	
Confusion		0	1	2	3	4	5	6	
Feeling "Slowed Down"		0	1	2	3	4	5	6	
Feeling "In a Fog"		0	1	2	3	4	5	6	
Drowsiness		0	1	2	3	4	5	6	
Fatigue/Low Energy		0	1	2	3	4	5	6	
More Emotional		0	1	2	3	4	5	6	
Irritability		0	1	2	3	4	5	6	
Difficulty Concentrating		0	1	2	3	4	5	6	

Please fill out both sides.

0 = None 6 = Severe (Symptoms as of Today)

Continued:									
Difficulty Remembering		0	1	2	3 	4	5	6	
Sadness		0	1	2	3 	4	5	6	
Trouble Falling Asleep		0	1	2	3 	4	5	6	
Sleeping More Than Usual		0	1	2	3 	4	5	6	
Sensitivity to Light		0	1	2	3 	4	5	6	
Sensitivity to Sound		0	1	2	3 	4	5	6	
Other: _____		0	1	2	3 	4	5	6	
Total:									

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