Patient's Name: _____ Date of Injury: _____ Today's Date: _____

Questionnaire for Post-Concussion Syndrome

(Traumatic Brain Injury - TBI)

Please place a check mark "√" in the space provided next to any and all of the following symptoms that you have noticed since your accident. If you are unsure, place a "?" in the space. If you should have any additional symptoms of an unusual nature, then please list them in the space provided at the bottom of the page. Thank you for your assistance.

_____ 1. Light-headedness
_____ 2. Vertigo/dizziness
_____ 3. Neck pain and/or stiffness
_____ 4. Headache
_____ 5. Photophobia (sensitivity to bright light)
_____ 6. Phonophobia (sensitivity to loud noises)
_____ 7. Tinnitus (ringing in the ears)
_____ 8. Impaired memory
_____ 9. Difficulty concentrating
_____ 10. Impaired comprehension or awareness
_____ 11. Forgetfulness
_____ 12. Impaired logical thinking
_____ 13. Difficulty with new or abstract concepts
_____ 14. Insomnia (difficulty sleeping
_____ 15. Easy fatigability
_____ 16. Apathy
_____ 17. Outbursts of anger
_____ 18. Mood swings
_____ 19. Depression
_____ 20. Loss of libido
_____ 21. Personality change
_____ 22. Intolerance to alcohol

Comments: _____

_____

_____

_____

Remember that you may be asked to complete this form on more than one occasion to monitor progress of your condition.