Stony Brook Medicine

Concussion Symptom Score

Athlete Name:_____ **Date of Injury:**_____

Rate the severity of each symptom on a scale of 0-6. Zero indicates you are not currently experiencing any symptoms.
1=Mild; 3=Moderate; 6=Severe

Symptom	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Blurred Vision										
Dizziness										
Excessive Sleep										
Easily Distracted										
Fatigue										
Feeling "in a fog"										
Feeling "slowed down"										
Headache										
Inappropriate emotions/more emotional										
Irritability										
Memory problems										
Nausea/vomiting										
Nervousness										
Numbness/tingling										
Personality changes										
Poor balance/coordination										
Poor concentration										
Sadness										
Sensitivity to light										
Sensitivity to noise										
Sleeping less than usual										
Trouble falling asleep										
Total Score:										