cbirt

UNIVERSITY OF OREGON

Post-Concussion Symptom Checklist

Name: ___________________________________ Date_____/______/__________

Instructions: For each item please indicate how much the symptom has bothered you over the **past 2 days.**

Symptom	None		Mild		Moderate		Severe
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
Visual problems	0	1	2	3	4	5	6
Fatigue	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
Numbness/tingling	0	1	2	3	4	5	6
Pain other than headache	0	1	2	3	4	5	6
Feeling mentally foggy	0	1	2	3	4	5	6
Feeling slowed down	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
Drowsiness	0	1	2	3	4	5	6
Sleeping less than usual	0	1	2	3	4	5	6
Sleeping more than usual	0	1	2	3	4	5	6
Trouble falling asleep	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
Feeling more emotional	0	1	2	3	4	5	6

Exertion: Do these symptoms worsen with:

Physical Activity Yes No Not applicable

Thinking/Cognitive Activity Yes No Not applicable

Overall Rating: How different are you acting compared to your usual self?

Same as Usual 0 1 2 3 4 5 6 Very Different

Activity Level: Over the past two days, compared to what you would typically do, your level of activity has been ________ % of what it would be normally.