Concussion Grading Scale

Name______________________Date___________________Time_______________

What were you doing before you came to Health Center or Athletic Training Center?
____

What time did you go to bed last night?____________Wake up this morning?_______________

Did you sleep through the night?_________________ Take any naps? _____________________

Symptom	None	Mild	Mild	Moderate	Moderate	Severe	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 (if applicable)	0	1	2	3	4	5	6
More emotional	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
Sleeping more than usual	0	1	2	3	4	5	6
Sleeping less than usual	0	1	2	3	4	5	6
Difficulty sleeping soundly	0	1	2	3	4	5	6
Ringing in the ears	0	1	2	3	4	5	6
Numbness or tingling	0	1	2	3	4	5	6
Sum of each column							
Total number of symptoms	of 27						
Symptom Severity Score	of 162						

Notes: ____