Daily Symptom Score Sheet

Name: ______________________________ **Date:** ____________

☐ **S1:** Symptomatic limited activities of daily living | ☐ **S2:** Non-impact aerobic activity | ☐ **S3:** Anaerobic interval training
☐ **S4:** Strength training/non-contact sport-specific drills | ☐ **S5:** Controlled contact practice | ☐ **S6:** Full contact practice

How do you feel?

*"You should score yourself on the following symptoms, based on how you feel **RIGHT** now".*

	None	Mild		Moderate		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	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

Do the symptoms get worse with physical activity? _______ Do the symptoms get worse with mental activity? _______

How do you feel compared to
how you felt prior to your concussion?
(e.g. 50%, 70%, 90%)

Overall _____________

Physical ____________

Emotional ___________

Cognitive ___________

Comments

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