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POST-CONCUSSION SYMPTOM SCALE

Name: _____ **Date:** _____ **FIN:** _____

Directions: After reading each symptom, please circle the number that best describes the way you have been feeling TODAY. A rating of 0 means you have not experienced this problem today. A rating of 6 means you have experienced severe problems with this symptom today.

PHYSICAL	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
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
PHYSICAL TOTAL (0-60)							

COGNITIVE	NONE	MILD		MODERATE		SEVERE	
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
COGNITIVE TOTAL (0-24)							

EMOTIONAL	NONE	MILD		MODERATE		SEVERE	
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6
EMOTIONAL TOTAL (0-24)							

SLEEP	NONE	MILD		MODERATE		SEVERE	
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
SLEEP TOTAL (0-24)							

TOTAL SYMPTOM SCORE (ADD PHYSICAL, COGNITIVE, EMOTIONAL, SLEEP TOTALS) (0-132) _____

Lavell & Collins, J Head Trauma Rehabil 1998; 13(2);9-26