Symptom Checklist

Name:_____**Date:**_____**Time:**_____

Date of Injury:_____**Completed by:**_____**School:**_____

Please use this form to record data on the student's signs/symptoms. Use as often as needed to help with educational programming and communication with the student's family and medical care team. *Adapted from Oregon Concussion Awareness and Management Program (OCAMP) and Adapted from the Nebraska BIRSST program*

	Symptoms	None	Mild		Moderate		Severe	
Physical	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
	Blurry/Double Vision	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
	Pain (other)	0	1	2	3	4	5	6
Cognition	Feeling "in a fog"	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
Sleep	Trouble falling asleep	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Drowsiness	0	1	2	3	4	5	6
Emotional	More or Less Emotional	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

Do symptoms worsen with physical activity? **Yes**____ **No**_____ **Not Applicable**_____

Do symptoms worsen with thinking/cognitive activity? **Yes**_____ **No**_____ **Not Applicable**_____

Activity Level: Over the past _____ days, compared to what I would typically do, my level of activity has been _____ **%** of what it would normally be.