



Concussion Symptom Checklist

Athlete Name: _____
Grade: _____ Age: _____
Date: _____ Sport: _____

Date of Injury _____

Symptom	Day of Injury 0-20 min	Final Evaluation (Post-event)	24 Hours Post-injury	48 Hours Post-injury	72 Hours Post-injury
Loss of Consciousness	Y N N/A				
Amnesia	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A
Seizures	Y N N/A				

The Certified Athletic Trainer should complete the following by asking the injured to grade or score the severity of the symptoms on a 0-6 scale, where 0=not present and 6=most severe

Symptom	Day of Injury 0-20 min	Final Evaluation (Post-event)	24 Hours Post-injury	48 Hours Post-injury	72 Hours Post-injury
Headache					
Nausea					
Vomiting					
Balance problems					
Dizziness					
Visual problems					
Fatigue					
Sensitivity to light					
Sensitivity to noise					
Numbness/tingling					
Feeling mentally foggy					
Feeling slowed down					
Difficulty concentrating					
Difficulty remembering					
Irritability					
Sadness					
More emotional					
Nervousness					
Drowsiness					
Sleeping less than usual					
Sleeping more than usual					
Trouble falling asleep					
TOTAL SCORE OF SYMPTOMS PRESENT:	/132	/132	/132	/132	/132

Date of Referral: _____



Concussion Symptom Checklist

Athlete Name: _____
Grade: _____ Age: _____
Date: _____ Sport: _____

The Certified Athletic Trainer should complete the following by asking the injured to grade or score the severity of the symptoms on a 0-6 scale, where 0=not present and 6=most severe

Symptom	4 days Post-injury	5 days Post-injury	6 days Post-injury	7 days Post-injury
Headache				
Nausea				
Vomiting				
Balance problems				
Dizziness				
Visual problems				
Fatigue				
Sensitivity to light				
Sensitivity to noise				
Numbness/tingling				
Feeling mentally foggy				
Feeling slowed down				
Difficulty concentrating				
Difficulty remembering				
Irritability				
Sadness				
More emotional				
Nervousness				
Drowsiness				
Sleeping less than usual				
Sleeping more than usual				
Trouble falling asleep				
TOTAL SCORE OF SYMPTOMS PRESENT:	/132	/132	/132	/132

Date of Referral: _____