Robert C. Cantu Concussion Center
Emerson Hospital

TIME OF INJURY CONCUSSION SIGNS / SYMPTOMS CHECKLIST

Enter an "X" for the symptoms you experienced within 48 hours of your most recent injury/concussion.

	None	Mild		Moderate		Severe			None	Mild		Moderate		Severe	
	0	1	2	3	4	5	6		0	1	2	3	4	5	6
Feeling In A Fog								**Balance Issues**							
Confusion								**Blurred Vision**							
Difficulty Concentrating								**Double Vision**							
Difficulty Remembering								**Dizziness**							
Don't Feel Right/ Dinged/Bell Rung								**Sleeping More than Usual**							
Feeling Mentally Slowed Down								**Sleeping Less than Usual**							
Headache/Head Pressure								**Drowsy**							
Numbness/Tingling								**Fatigue/Low Energy**							
Nausea/Vomiting								**Trouble Falling Asleep**							
Sensitivity to Light								**Sadness**							
Sensitivity to Noise								**Nervous/ Anxious**							
Neck Pain								**Irritable**							
Ringing in the Ears								**Feeling More Emotional**							

Date _____ Time _____ Patient's Name _____

For Office Use Only:

C _____/6 SO _____/7 V_____/4 SL _____/5 E _____/4

C _____/36 SO _____/42 V_____/24 SL _____/30 E _____/24

Total Symptom Load _____/26 Total Symptom Score_____/156

Date: _____ Time: _____ Signature: _____