CIF GRADED CONCUSSION SYMPTOM CHECKLIST

Today's Date: _____ **Time:** _____ **Hours of Sleep:** _____ **Date of Diagnosis:** _____

☐ **Baseline Score**
☐ **Post Concussion Score**

- **Grade the 22 symptoms with a score of 0 through 6.**
  - *Note that these symptoms may not all be related to a concussion.*
- **You can fill this out at the beginning of the season as a baseline** *(after a good night's sleep).*
- **If you suffer a suspected concussion, use this checklist to record your symptoms daily.**
  - *Be consistent and try to grade either at the beginning or end of each day.*
- **There is no scale to compare your total score to; this checklist helps you follow your symptoms on a day-to-day basis.**
  - *If your total scores are not decreasing, see your physician right away.*
- **Show your baseline (if available) and daily checklists to your physician.**

	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 than usual	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
TOTAL SUM OF EACH COLUMN	0						
TOTAL SYMPTOM SCORE *(Sum of all column totals)*							

NAME _____ **HIGH SCHOOL** _____

D.O.B. _____ **SPORT** _____ **PHYSICIAN (MD/DO)** _____