Center Grove High School Athletic Training
Concussion Daily Symptom Checklist

Name: **Sport:** **Injury date:** **Initial eval date:**

Score yourself on the following symptoms, based on how you feel now

None	Mild	Moderate	Severe
0	1 2	3 4	5 6

Symptom Checklist	Initial	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
Headache											
"Pressure in head"											
Neck pain											
Nausea/vomiting											
Dizziness											
Blurred vision											
Balance problems											
Sensitivity to light											
Sensitivity to noise											
Feeling Slowed down											
Feel like your "in a fog"											
"Don't feel right"											
Difficulty concentrating											
Difficulty remembering											
Fatigue/low energy											
Confusion											
Drowsiness											
More emotional											
Irritability											
Sadness											
Nervous/anxious											
Trouble falling asleep											
Total:											
Number of Symptoms											
ATC:											
Date:											
Time:											