THE UNIVERSITY OF KANSAS HEALTH SYSTEM
ST. FRANCIS CAMPUS

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Post-Concussion Symptoms Checklist

Name: _____ **Date:** _____

Instructions: For each item, please indicate how much the symptom has bothered you over the past day.
Score 0-6 (0=none, 6=severe)

	Date							
Physical	Headache							
	Nausea							
	Vomiting							
	Balance Problem							
	Dizziness							
	Visual Problems							
	Fatigue							
	Sensitivity to light							
	Sensitivity to noise							
	Numbness/tingling							
	Pain other than headache							
Thinking	Feeling mentally foggy							
	Feeling slowed down							
	Difficulty concentrating							
	Difficulty remembering							
Sleep	Drowsiness							
	Sleeping less than usual							
	Sleeping more than usual							
	Trouble falling asleep							
Emotional	Irritability							
	Sadness							
	Nervousness							
	Feeling more emotional							
	Total							

Exertion: Do these symptoms worsen with:
Physical Activity: ☐ Yes ☐ No ☐ Not Applicable
Thinking/Cognitive Activity: ☐ Yes ☐ No ☐ Not Applicable

Overall Rating: Over the past 2 days, compared to normal, I would rate myself at ___% of normal.