Please print, complete and bring this form to your appointment.

PATIENT NAME:_____ **DATE OF BIRTH**_____

Concussion Grading Scale

The Post Concussion Symptom Scale is essentially a "state" measure of perceived symptoms associated with concussion. That is, the athlete is asked to report his or her "current" experience of symptoms. This allows tracing of symptoms over very short intervals, such as consecutive days or every few days.

Directions: After reading each symptom, please circle the number that best describes the way the athlete has been feeling today. A rating of 0 means they have not experienced this symptoms today. A rating of 6 means they have experienced severe problems with this symptom today.

Date tested:_____ **Date(s) of Last Known Concussion(s):**_____

SYMPTOMS	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Fatigue	0	1	2	3	4	5	6
Trouble Falling Asleep	0	1	2	3	4	5	6
Sleeping More Than Usual	0	1	2	3	4	5	6
Sleeping Less Than Usual	0	1	2	3	4	5	6
Drowsiness	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
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6
Feeling More Emotional	0	1	2	3	4	5	6
Numbness or Tingling	0	1	2	3	4	5	6
Feeling Slowed Down	0	1	2	3	4	5	6
Feeling Mentally "Foggy"	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
Visual Problems (double vision, blurring, etc.	0	1	2	3	4	5	6
TOTAL SYMPTOM SCORE:							
GRAND TOTAL OF ALL SYMPTOMS:							

ImPACT requires the subject to rate the severity of 22 concussive symptoms (e.g.) headache, dizziness, sensitivity to light, etc), via a 7-point Likert scale.