The Center for Concussion Management

Graded Symptom Checklist

Name: _____ Date: ____/____/____ Time: _____

Date of last concussion: ____/____/_____ Total hours of sleep last night: _____hours

Current medications:_____

Please check the box below that indicates the degree to which you are CURRENTLY experiencing the following symptoms:

No symptoms"0"-------Moderate "3"---------Severe"6"

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 to sleep	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Excessive sleep	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Loss of sleep	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Drowsiness	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Light sensitivity	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Noise sensitivity	☐	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
More emotional	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Numbness	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Feeling "slow"	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Feeling "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	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6

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