advocare | Vernon Pediatric & Family Care

Name _____Date of Birth _____ Age _____
Date of Injury _____Sport/Position _____ School _____
Primary Care Physician _____

This form should be completed by the child before he/she is evaluated by a physician. The second page (reverse side) should be completed by the parent. Symptom scores should be recorded daily.

□ Self-Rated □ Clinician interview □ Parent interview □ Self-rated with clinician/parent monitoring

CHILD (5-12) Symptom Evaluation How do you feel now? Score your symptoms: **never** 0 **rarely** 1 **sometimes** 2 **often** 3		**1** **Date**	**2** **Date**	**3** **Date**	**4** **Date**	**5** **Date**	**6** **Date**	**7** **Date**
PHYSICAL	1. I have headaches							
	2. I feel dizzy							
	3. I feel like the room is spinning							
	4. I feel like I'm going to faint							
	5. Things are blurry when I look at them							
	6. I see double							
	7. I feel sick to my stomach							
	8. Light bothers me							
	9. Noises bother me							
	10. I get tired easily							
COGNITVE	11. I have trouble paying attention							
	12. I get distracted easily							
	13. I have problems remembering what people tell me							
	14. I have problems following directions							
	15. I daydream too much							
	16. I get confused							
	17. I forget things							
	18. I have problems finishing things							
	19. I have problems figuring things out							
	20. It's hard for me to learn new things							
SLEEP	21. I get tired a lot							
	22. I can't sleep							
	23. What percentage (%) of my normal self I feel like today							

----------FOR OFFICE USE ONLY----------

	Total # of symptoms (22 max)							
	Symptom severity (66 max)							

Child's Name:_____ Date of Birth _____ Age _____

This form should be completed by the child before he/she is evaluated by a physician. The second page (reverse side) should be completed by the parent. Symptom scores should be recorded daily.

□ Self-Rated □ Clinician interview □ Parent interview □ Self-rated with clinician/parent monitoring

RENT Symptom Evaluation How do you think your child feels now? Score his/her symptoms: **never** **rarely** **sometimes** **often** 0 1 2 3		**1** **Date**	**2** **Date**	**3** **Date**	**4** **Date**	**5** **Date**	**6** **Date**	**7** **Date**
PHYSICAL	1. has headaches							
	2. feels dizzy							
	3. has a feeling that the room is spinning							
	4. feel faint							
	5. has blurred vision							
	6. has double vision							
	7. experiences nausea							
	8. has light sensitivity							
	9. has noise sensitivity							
	10. gets tired easily							
COGNITIVE	11. has trouble sustaining attention							
	12. is easily distracted							
	13. has problems remembering what he/she is told							
	14. has difficulty following directions							
	15. tends to daydream							
	16. gets confused							
	17. is forgetful							
	18. has difficulty completing tasks							
	19. has poor problem solving skills							
	20. has problems learning							
SLEEP	21. is fatigued and sleeps more							
	22. has difficulty sleeping							
	23. what percentage (%) of normal is he/she today							

----------FOR OFFICE USE ONLY----------

	Total # of symptoms (22 max)							
	Symptom severity (66 max)							