

### Graded Symptom Checklist

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

**Instructions:** Indicate how much each symptom has bothered you in the *last 48 hours, or since the time of your injury*

	Symptoms	None	Mild		Moderate		Severe	
Physical	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
	Blurred/Visual Problems	0	1	2	3	4	5	6
	Fatigue	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
	Numbness/Tingling	0	1	2	3	4	5	6
	Ringling in Ears	0	1	2	3	4	5	6
Thinking	Easily Distracted	0	1	2	3	4	5	6
	Feeling Mentally Foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping Less/Disturbances	0	1	2	3	4	5	6
	Sleeping more than Usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotional	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
	Personality Changes	0	1	2	3	4	5	6
Other (please describe below)		0	1	2	3	4	5	6
Total Score =								

Did you lose consciousness due to your accident?  Yes  No

Did you sustain a blow to the head?  Yes  No  
 Location of impact  Frontal  Left Temple  Right Temple  Top of Head  Back of Head

Do any of the above symptoms worsen with,  
 Physical Activity  Yes  No  Not Applicable  
 Thinking/School/Work/Cognitive Activity  Yes  No  Not Applicable

Over the past 2 days, what percent of your daily activity level is normal? \_\_\_\_\_%