LFHS CONCUSSION SYMPTOM INVENTORY

Athlete Name: _____ Class/Year: _____ Injury Date: _____

Loss of Conciousness (circle): YES NO Previous Concussion Dates: _____ _____ _____ _____

SYMPTOMS	SEVERITY RATING (SCALE 0 TO 6)							
	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Headache								
Nausea								
Vomiting								
Balance Problems								
Dizziness								
Fatigue								
Trouble falling asleep								
Sleeping more than usual								
Sleeping less than usual								
Drowsiness								
Sensitivity to light								
Sensitivity to noise								
Irritability								
Sadness								
Nervousness								
Feeling more emotional								
Numbness or tingling								
Feeling slowed down								
Feeling mentally foggy								
Difficulty concentrating								
Difficulty remembering								
Visual problems								
Total Symptom Score:								
SAC/SCAT Score:								
Balance Score:								
Athletic Trainer Initials:								