Name: _____ Date: _____

Self-Reported Rating of Concussion Symptoms v2.0

Please rate the following symptoms by circling the best answer on the 0-6 scale, averaging up to past 2 weeks

1 = minor, 2 = annoying, 3 = moderate, 4 = significant, 5 = intense and disruptive, 6 = worst and unbearable

Symptom	Frequency								Intensity							
	None	Mild 1-25%		Moderate 25-50%		Severe >50% 100%			Mild		Moderate		Severe		F	I
Headache	0	1	2	3	4	5	6	*	1	2	3	4	5	6		
Nausea	0	1	2	3	4	5	6		1	2	3	4	5	6		
Vomiting	0	1	2	3	4	5	6		1	2	3	4	5	6		
Balance problems	0	1	2	3	4	5	6		1	2	3	4	5	6		
Dizziness	0	1	2	3	4	5	6	*	1	2	3	4	5	6		
Blurred or double vision	0	1	2	3	4	5	6		1	2	3	4	5	6		
Fatigue or low energy	0	1	2	3	4	5	6	*	1	2	3	4	5	6		
Sensitivity to light	0	1	2	3	4	5	6		1	2	3	4	5	6		
Sensitivity to noise	0	1	2	3	4	5	6		1	2	3	4	5	6		
Numbness/Tingling	0	1	2	3	4	5	6		1	2	3	4	5	6		
Ringing in Ears (tinnitus)	0	1	2	3	4	5	6		1	2	3	4	5	6		
Feeling of ‘brain fog’	0	1	2	3	4	5	6		1	2	3	4	5	6		
Difficulty ‘word finding’	0	1	2	3	4	5	6		1	2	3	4	5	6		
Mentally slowed down	0	1	2	3	4	5	6		1	2	3	4	5	6		
Difficulty concentrating	0	1	2	3	4	5	6	*	1	2	3	4	5	6		
Difficulty remembering	0	1	2	3	4	5	6	*	1	2	3	4	5	6		
Spontaneous laugh or cry	0	1	2	3	4	5	6		1	2	3	4	5	6		
Irritability	0	1	2	3	4	5	6	*	1	2	3	4	5	6		
Sadness or Depression	0	1	2	3	4	5	6		1	2	3	4	5	6		
Nervousness or Anxiety	0	1	2	3	4	5	6		1	2	3	4	5	6		
Drowsiness during the day	0	1	2	3	4	5	6		1	2	3	4	5	6		
Sleeping less than usual	0	1	2	3	4	5	6	*	1	2	3	4	5	6		
Sleeping more than usual	0	1	2	3	4	5	6	*	1	2	3	4	5	6		
Trouble falling asleep	0	1	2	3	4	5	6	*	1	2	3	4	5	6		
Reduced tolerance: stress, emotions or substances	0	1	2	3	4	5	6	*	1	2	3	4	5	6		

Meets diagnostic criteria F07.81 YES NO

Symptom Frequency: _____/150, Symptom Intensity: _____/150, Composite (add [F & I]/3): _____%