



Family Health Associates

Concussion Clinic

(541) 567-6434

www.FHAcares.com



Symptom Inventory

Ages 12 & Older

Patient Name: _____ DOB: _____ Date: _____

	None	Mild		Moderate		Severe		
Headache	0	1	2	3	4	5	6	
“Pressure in head”	0	1	2	3	4	5	6	
Neck pain	0	1	2	3	4	5	6	
Nausea or vomiting	0	1	2	3	4	5	6	
Dizziness	0	1	2	3	4	5	6	
Blurred vision	0	1	2	3	4	5	6	
Balance problems	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	
Feeling slowed down	0	1	2	3	4	5	6	
Feeling like “in a fog”	0	1	2	3	4	5	6	
“Don’t feel right”	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	
Fatigue or low energy	0	1	2	3	4	5	6	
Confusion	0	1	2	3	4	5	6	
Drowsiness	0	1	2	3	4	5	6	
More emotional	0	1	2	3	4	5	6	
Irritability	0	1	2	3	4	5	6	
Sadness	0	1	2	3	4	5	6	
Nervous or anxious	0	1	2	3	4	5	6	
Trouble falling asleep	0	1	2	3	4	5	6	
Total number of symptoms:							of 22	
Symptoms severity score:							of 132	
Do your symptoms get worse with physical activity?							Y	N
Do your symptoms get worse with mental activity?							Y	N
If 100% is feeling perfectly normal, what percent of normal do you feel?								

If not 100%, why?
