SPORT & SPINE REHAB
CHIROPRACTIC | PHYSICAL THERAPY | REHAB
Work Better, Play Harder

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
	Ringing 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 your 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? _____%