Colorado Springs Office
1710 Jet Stream Dr, Ste 215
Colorado Springs, CO 80921
Phone: 719-302-8922
Fax: (719) 694-8480

Castle Rock Office
4344 Woodlands Blvd, Ste 160
Castle Rock, CO 80104
Phone: 720-726-5128
Fax: (719) 694-8480

Post-Concussion Symptom Scale

Name: _____ Date: _____ Date of Injury: _____

SEVERITY RATING

Please use this scale to rate each symptom.

None		Mild		Moderate		Severe
0	1	2	3	4	5	6

Symptoms	Date:	Date:	Date:	Date:	Date:	Date:
Headache						
Nausea						
Vomiting						
Balance Problems						
Dizziness (spinning or movement sensation)						
Lightheadedness						
Fatigue						
Trouble falling asleep						
Sleeping more than usual						
Sleeping less than usual						
Drowsiness						
Sensitivity to light						
Sensitivity to noise						
Irritability						
Sadness						
Nervous/Anxious						
Feeling more emotional						
Numbness or tingling						
Feeling slowed down						
Feeling like “in a fog”						
Difficulty concentrating						
Difficulty remembering						
Visual problems						
Other:						
Total						

Check any professionals that you have worked with or are currently working with:

Occupational Therapy _____ **Physical Therapy** _____ **Neurologist**_____ **Chiropractor**_____

Other: _____