AdventHealth
Medical Group

SYMPTOM SCORING SHEET

Name: _____ Date: _____

Sport/ Position: _____Date of Injury_____

Symptom Inventory: Rate your CURRENT symptoms

Rate each symptom on scale from 0 to 6
(0 no symptoms, 1 minimal symptom – 6 maximum/ worst symptoms ever)

CURRENT SYMPTOMS	None	Minor		Moderate		Severe		Last 24 hrs ✓if Yes
Headache	0	1	2	3	4	5	6	
Nausea	0	1	2	3	4	5	6	
Vomiting	0	1	2	3	4	5	6	
Dizziness	0	1	2	3	4	5	6	
Fatigue	0	1	2	3	4	5	6	
Drowsiness	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	
Irritability	0	1	2	3	4	5	6	
Sadness	0	1	2	3	4	5	6	
Nervousness	0	1	2	3	4	5	6	
Numbness or tingling	0	1	2	3	4	5	6	
Feeling more emotional	0	1	2	3	4	5	6	
Feeling slowed down	0	1	2	3	4	5	6	
Visual problems (double vision, blurring)	0	1	2	3	4	5	6	
Feeling mentally “foggy”	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	
SYMPTOMS BASED ON LAST NIGHT								
Trouble falling asleep	0	1	2	3	4	5	6	
Sleeping more than usual	0	1	2	3	4	5	6	
Sleeping less than usual	0	1	2	3	4	5	6	
		TOTAL SYMPTOM SCORE						