NAME:
DATE:

FOLLOW-UP CONCUSSION QUESTIONNAIRE

Please comment on any symptoms you have experienced **in the last 24 hours**?

PHYSICAL:

Headache	Yes	No	Dizziness	Yes	No
Nausea	Yes	No	Visual Problem	Yes	No
Vomiting	Yes	No	Fatigue	Yes	No
Balance Problem	Yes	No	Numbness/tingling	Yes	No
Sensitivity to light	Yes	No			
Sensitivity to noise	Yes	No			

COGNITIVE:

Mentally foggy	Yes	No	Feeling slowed down	Yes	No
Difficulty remembering	Yes	No	Difficulty concentrating	Yes	No

EMOTIONAL:

Irritability	Yes	No	More Emotional	Yes	No
Sadness	Yes	No	Nervousness	Yes	No

SLEEP:

Drowsy	Yes	No	Sleep more than usual	Yes	No
Trouble Falling Asleep	Yes	No	Sleep less than usual	Yes	No

Do symptoms worsen with either of the following kinds of activity?

With Physical Activity	Yes	No
With Cognitive Activity	Yes	No

How different are you acting versus your normal self?

0 is normal — 6 is very different

0 1 2 3 4 5 6