ACUTE CONCUSSION QUESTIONNAIRE

NAME:

DATE:

1. When did your injury occur?
2. Was there a direct blow to your head? Yes No
3. Is there/was there swelling or a wound on your head? Yes No
4. What was the location of the impact?

   Front of head____ Right side of head_____

   Back of head____ Left side of head____
5. Do you have any problem remembering what happened?

   a. Before the injury (Retrograde Amnesia)? Yes No

   b. After the injury (Anterograde Amnesia)? Yes No
6. Did you lose consciousness? Yes No
7. Did you appear dazed, stunned, confused, or were you answering slowly, repeating questions you were asked? Yes No
8. Did you have a seizure? Yes No
9. Since your injury, what symptoms have you experienced?

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

10. Do symptoms worsen with either of the following?

    With Physical Activity Yes No With Cognitive Activity Yes No
11. How different are you acting now compared with your normal self?

    0 is normal 6 is very different

    0 1 2 3 4 5 6