SEACOAST ORTHOPEDICS & SPORTS MEDICINE

Concussion - Daily Monitoring Sheet

NAME: _____ DATE: _____

DATE OF INJURY: _____

Symptom	None	Mild		Moderate			Severe
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 PROBLEM/ DIZZINESS	0	1	2	3	4	5	6
FATIGUE	0	1	2	3	4	5	6
SKIN RASH/ ITCHING	0	1	2	3	4	5	6
TROUBLE SLEEPING	0	1	2	3	4	5	6
SLEEPING MORE THAN USUAL	0	1	2	3	4	5	6
DROWSINESS	0	1	2	3	4	5	6
SENSITIVITY TO LIGHT	0	1	2	3	4	5	6
BLURRED VISION	0	1	2	3	4	5	6
SENSITIVITY TO NOISE	0	1	2	3	4	5	6
JOINT STIFFNESS (FINGERS)	0	1	2	3	4	5	6
SADNESS	0	1	2	3	4	5	6
IRRITABILITY	0	1	2	3	4	5	6
NUMBNESS/ TINGLING	0	1	2	3	4	5	6
FEELING LIKE “IN A FOG”	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
NECK PAIN	0	1	2	3	4	5	6
Column Total Score (add #s)	_	_	_	_	_	_	_

Total # of Items Endorsed: _____ Overall Total Score: _____

Assuming you were at 100% before your concussion, give a percentage rate to your current overall condition: _____%