LAKE DALLAS INDEPENDENT SCHOOL DISTRICT

Graded Symptom Checklist

Name:_____ AM/PM Check

Date: _____

Symptom	None	Minor		Moderate		Severe	
Headache	0	1	2	3	4	5	6
Pressure in head	0	1	2	3	4	5	6
Neck pain	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Light sensitivity	0	1	2	3	4	5	6
Noise sensitivity	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"don't feel right"	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
Extremely tired or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Feelings are out of control	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
Annoyed or Easily angered	0	1	2	3	4	5	6
Irritability (cranky)	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or anxious	0	1	2	3	4	5	6
Worry for no reason	0	1	2	3	4	5	6
Ringing in Ears	0	1	2	3	4	5	6

Total number of symptoms (Max = 24) _____/24

Symptom Severity Score (Max = 144)_____/144

Notes:

I certify that the information above is accurate and correct.

Student Signature: _____ Athletic Trainer Signature:_____