Stanford HEALTH CARE

Concussion Questionnaire

Date of Injury: _____

Please use the following scale to rate your symptoms as listed below:

0 = Never Experienced
1 = Mild
2 = Moderate
3 = Severe
R = Resolved

Dizziness	0	1	2	3	R
Headaches	0	1	2	3	R
Hearing changes	0	1	2	3	R
Vision Changes	0	1	2	3	R
Balance Changes	0	1	2	3	R
Nausea and/or Vomiting	0	1	2	3	R
Light Sensitivity, bothered by bright light	0	1	2	3	R
Noise Sensitivity, bothered by loud noise	0	1	2	3	R
Sleep Disturbance	0	1	2	3	R
Fatigue, Tiring More Easily	0	1	2	3	R
Being Irritable, Easily Angered	0	1	2	3	R
Feeling Depressed or Tearful	0	1	2	3	R
Feeling Anxious or Tense	0	1	2	3	R
Poor Memory	0	1	2	3	R
Poor Concentration	0	1	2	3	R
Feeling Mentally Foggy	0	1	2	3	R