Fort Worth Independent School District

Concussion Daily Symptoms Checklist

Athlete Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_ Date of Injury:\_\_\_\_\_\_\_\_\_\_\_\_

Campus:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sport:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Page \_\_\_\_ of \_\_\_\_\_**

 0 1 2 3 4 5 6

 None Moderate Severe

 *NOTE: Grading of symptoms on a scale of 0-6*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Symptoms | Date &Time | Date &Time | Date &Time | Date &Time | Date &Time | Date &Time | Date &Time |
|  |  |  |  |  |  |  |
| Headache |  |  |  |  |  |  |  |
| “Pressure in head” |  |  |  |  |  |  |  |
| Neck Pain |  |  |  |  |  |  |  |
| Nausea/Vomiting |  |  |  |  |  |  |  |
| Balance Problems |  |  |  |  |  |  |  |
| Dizziness |  |  |  |  |  |  |  |
| Visual Problems |  |  |  |  |  |  |  |
| Fatigue/Low Energy |  |  |  |  |  |  |  |
| Sensitivity to Light |  |  |  |  |  |  |  |
| Sensitivity to Noise |  |  |  |  |  |  |  |
| Numbness/Tingling |  |  |  |  |  |  |  |

**Physical Findings**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Feeling Slowed Down |  |  |  |  |  |  |  |
| Feeling Mentally “Foggy” |  |  |  |  |  |  |  |
| “Don’t Feel Right” |  |  |  |  |  |  |  |
| Difficulty Concentrating |  |  |  |  |  |  |  |
| Difficulty Remembering |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Irritability |  |  |  |  |  |  |  |
| Sadness |  |  |  |  |  |  |  |
| More Emotional |  |  |  |  |  |  |  |
| Nervous/Anxious |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Drowsiness |  |  |  |  |  |  |  |
| Sleeping Less |  |  |  |  |  |  |  |
| Sleeping More |  |  |  |  |  |  |  |
| Trouble Falling Asleep |  |  |  |  |  |  |  |

**Cognitive**

**Findings**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Number of Symptoms Severity (Add the Symptoms) |  |  |  |  |  |  |  |
| Signature of Symptom Assessor |  |  |  |  |  |  |  |

**Sleep**

**Findings**

**Emotional**

**Findings**