

# Cerebral Concussion

NAME: \_\_\_\_\_

## Directions

DATE: \_\_\_\_\_

The Post concussion Symptom Scale is essentially a "state" measure of perceived symptoms associated with concussion. That is, the athlete is asked to report his or her "current" experience of the symptoms. This allows tracking of symptoms over very short intervals, such as consecutive days or every few days. After reading each symptom, please circle the number that best describes the way the athlete has been feeling today. A rating of 0 means they have not experienced this symptom today. A rating of 6 means they have experienced severe problems with this symptom today.

Date tested							
Date of Last known concussion(s)							
<b>SYMPTOM</b>	<b>None</b>	<b>Mild</b>		<b>Moderate</b>		<b>Severe</b>	
Patient Type	0	1	2	3	4	5	6
Headaches	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Fatigue	0	1	2	3	4	5	6
Trouble Falling Asleep	0	1	2	3	4	5	6
Sleeping Longer	0	1	2	3	4	5	6
Sleeping Less	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Intolerance to Light	0	1	2	3	4	5	6
Intolerance to Noise	0	1	2	3	4	5	6
Irritation	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6
Stronger Emotions	0	1	2	3	4	5	6
Numbness or Tingling	0	1	2	3	4	5	6
Mentally Slower	0	1	2	3	4	5	6
Mentally Blurred	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
Visual Problems	0	1	2	3	4	5	6
TOTAL SYMPTOM SCORE:							
GRAND TOTAL OF ALL SYMPTOMS:							

# HEADACHE DISABILITY INDEX

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SCORES TOTAL: \_\_\_\_\_; E \_\_\_\_\_; F \_\_\_\_\_  
 (100) (52) (48)

**INSTRUCTIONS: Please CIRCLE the correct response:**

1. I have headache: [1] 1 per month [2] more than but less than 4 per month [3] more than one per week.  
 2. My headache is: [1] mild [2] moderate [3] severe

**INSTRUCTIONS: PLEASE READ CAREFULLY:** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off “YES”, “SOMETIMES”, or “NO” to each item. Answer each item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.			
F2. Because of my headaches I feel restricted in performing my routine daily activities.			
E3. No one understands the effect my headaches have on my life.			
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches			
E5. My headaches make me angry.			
E6. Sometimes I feel that I am going to lose control because of my headaches			
F7. Because of my headaches I am less likely to socialize.			
E8. My spouse/significant other, or family and friends have no idea what I am going through because of my headaches.			
E9. My headaches are so bad that I feel I am going to go insane.			
E10. My outlook on the world is affected by my headaches.			
E11. I am afraid to go outside when I feel a headache is starting.			
E12. I feel desperate because of my headaches.			
F13. I am concerned that I am paying penalties at work or at home because of my headaches.			
E14. My headaches place stress on my relationships with family or friends.			
F15. I avoid being around people when I have a headache.			
F16. I believe my headaches are making it difficult for me to achieve my goals in life.			
F17. I am unable to think clearly because of my headaches.			
F18. I get tense (e.g. muscle tension) because of my headaches.			
F19. I do not enjoy social gatherings because of my headaches.			
E20. I feel irritable because of my headaches.			
F21. I avoid traveling because of my headaches.			
E22. My headaches make me feel confused.			
E23. My headaches make me feel frustrated.			
F24. I find it difficult to read because of my headaches.			
F25. I find it difficult to focus my attention away from my headaches and on other things.			

Name \_\_\_\_\_ Date \_\_\_\_\_

### VISUAL VERTIGO ANALOGUE SCALE

(Adapted from Longridge et al., 2002)

Indicate the amount of dizziness you experience in the following situations by marking off the scales below.

0 represents no dizziness 😊 and 10 represents the most dizziness 🤯 .

(answer by drawing straight vertical line)

