Patient Name: _____

Date of Birth: _____

RETURN VISIT

*** On the chart below, please circle only those symptoms that STARTED when you sustained your concussion, and are STILL bothering you in the last 24 HOURS.***

If you have always had a certain symptom, like trouble paying attention, and it is the same as always, then circle 0. But if it is worse than normal choose 1 to 6.

(Please choose only ONE number for each symptom.)

Somatic Symptoms	None	Mild		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
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6

Vestibular Symptoms	None	Mild		Moderate		Severe	
Balance problems or dizziness	0	1	2	3	4	5	6
Hearing problems / ringing	0	1	2	3	4	5	6
Vision problems	0	1	2	3	4	5	6

Emotional Symptoms	None	Mild		Moderate		Severe	
More emotional than usual	0	1	2	3	4	5	6
Irritable	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

Cognitive Symptoms	None	Mild		Moderate		Severe	
Confusion	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
"Don't feel right"	0	1	2	3	4	5	6
Feeling "dinged" or "dazed"	0	1	2	3	4	5	6

Sleep Symptoms	None	Mild		Moderate		Severe	
Feeling slowed down	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
Sleeping more than usual	0	1	2	3	4	5	6

Total PCSS: _____

1. What is the most troublesome symptom that you are still having (if any)? _____

2. What are you most concerned about, if anything, regarding your concussion? _____

_____

3. On what day did you sustain your most recent concussion? _____*(mm/dd/yyyy)*

4. During which sport did you sustain your most recent concussion? _____

Headache Questionnaire

***If you are no longer having headaches from your concussion, please skip this section*.**

a. How often do your headaches occur? ***Please circle all that apply***

Constantly Daily intermittently Every other day A few days/week A few days/month

Other (please list): _____

b. Have you used medications to treat this concussion? ***If yes, please circle all that apply***

Acetaminophen (Tylenol) Ibuprofen (Advil, Motrin) Naproxen (Aleve)

Prescription medications (ex. Amitriptyline, Elavil, Gabapentin, Neurontin, Topamax, Topirimate)

Other medications:_____

Which medication has worked the best? _____

c. ***(Circle all that you have tried)*** **Acupuncture physical therapy massage therapy chiropractor**

d. Other treatments (please list): _____

e. What makes your headaches worse? ***Please circle all that apply***

Movement Noise Light School work Poor sleep

TV Exercise Computer Reading Smartboard at School

Other (please list): _____

f. What makes your headache better? ***Please circle all that apply***

Rest Medication Sleep Darkness Other: _____

g. How would you best describe your headaches? ***Please circle all that apply***

Pressure Pounding Throbbing Sharp Aching Like a band

Other (please list): _____

5. How much school have you missed because of your concussion since your last appointment? *(Please circle)*

None (No school missed) 2-4 days 1-2 weeks More than 1 month

1 day 5-7 days 2-4 weeks

6. Have you needed academic adjustments at school *(example: extra time for tests, reduced workload)*?

(Please circle) Yes No

7. Has your recent school work (including grades on quizzes or tests) been as good as your pre-injury work?

(Please circle) Yes No

8. Since your injury, have you been exercising?

(Please circle) Yes No

9. Did your symptoms return during or after the physical activity?

(Please circle) Yes No

10. Please list all medication you are currently taking:

_____ _____ _____

_____ _____ _____

MD Sign/Date: _____