ADVANTAGE
ORTHOPEDIC AND SPORTS MEDICINE CLINIC
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SYMPTOM EVALUTION

Name:_____ DOB:_____

Date:_____ Date of Injury:_____

How do you feel? ***You should score on the following symptoms, based on how you feel now***

	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
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
Sensitivity to noise	0	1	2	3	4	5	6
Sensitivity to light	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
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritability	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

Total number of symptoms (maximum possible 22) ☐

Symptom severity score (maximum number of 132) ☐

Do the symptoms get worse with physical activity? Y☐ N☐

Do the symptoms get worse with mental activity? Y☐ N☐

_____ _____

(signature of athlete) *(date)*

_____ _____

(signature of parent/guardian) *(date)*