ImPACT© Symptoms Report

Name _____

Date _____

Date of Concussion _____

SYMPTOMS							
Headache	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 More Than Usual	0	1	2	3	4	5	6
Sleeping Less Than Usual	0	1	2	3	4	5	6
Drowsiness	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
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6
Feeling More Emotional	0	1	2	3	4	5	6
Numbness and Tingling	0	1	2	3	4	5	6
Feeling Slowed Down	0	1	2	3	4	5	6
Feeling Mentally “Foggy”	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