



# ImPACT® Post-Concussion Symptom Scale



ORTHOWASHINGTON

Patient Name:

DOB:  Date:

Please rate the severity from 0 to 6 (None to Severe) of each symptom listed below by circling the appropriate number on the scale:

Symptom	None	1	Mild	2	Moderate	3	4	5	6	Severe
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 (spinning or movement sensations)	0	1	2	3	4	5	6			
Lightheadedness	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 / Anxiousness	0	1	2	3	4	5	6			
Feeling More Emotional	0	1	2	3	4	5	6			
Numbness or Tingling	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			
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			
Other	0	1	2	3	4	5	6			
<b>Total</b>										