University of the Cumberlands
Symptomology Assessment Scale

Name____ Sex M / F Date________________________________

Sport(s)_________________________ Baseline Test / Re-Exam Examiner_____________________________

Have you ever been knocked out? Yes / No If "Yes" how many times?______________________

Have you ever been diagnosed with a concussion? Yes / No If "Yes" how many times?______________________

Have you been evaluated using X-ray / CT Scan / MRI or other for a past head injury? Yes / No

If "Yes" please indicate the date (Month/Year):_____________________________

System checklist: Circle "yes" if you routinely experience the symptom or "no" if you do not routinely experience the symptom.

headache	yes	no
nausea / upset stomach	yes	no
fatigue / overly tired	yes	no
sleep difficulty	yes	no
drowsiness / Sleepiness	yes	no
appetite trouble	yes	no
sensitivity to light	yes	no
headache brought on by exercise	yes	no
difficulty balancing /dizziness	yes	no
feeling like you are "in a fog"	yes	no
difficulty concentrating	yes	no
feeling "slowed down"	yes	no
blurred or double vision	yes	no

If you answered "Yes" to any of the above symptoms please go to the corresponding symptom below and using the outlined directions indicate your symptom experience.

Symptom Scale: *For the duration side of the scale, circle the number that best describes how long you routinely experience each symptom.* ***"1" indicates that you briefly experienced the symptom before it resolved. "6" indicates that the symptom has been a constant experience..*** *Once you finish reporting the duration, please respond to the severity scale by circling the number that best describes how severe the symptom has felt to you* ***"1" indicates that the symptom felt mildly, "6" indicates the symptom was as severe as you could possibly imagine***.

	DURATION						SEVERITY					
	brief------------------------------constant						not severe -----------as severe as possible					
Headache	1	2	3	4	5	6	1	2	3	4	5	6
Headache-Exercise Induced	1	2	3	4	5	6	1	2	3	4	5	6
Nausea / Upset Stomach	1	2	3	4	5	6	1	2	3	4	5	6
Difficulty balancing / dizziness	1	2	3	4	5	6	1	2	3	4	5	6
Fatigue / overly tired	1	2	3	4	5	6	1	2	3	4	5	6
Feeling "in a fog"	1	2	3	4	5	6	1	2	3	4	5	6
Sleep difficulty	1	2	3	4	5	6	1	2	3	4	5	6
Difficulty concentrating	1	2	3	4	5	6	1	2	3	4	5	6
Drowsiness / Sleepiness	1	2	3	4	5	6	1	2	3	4	5	6
Feeling "slowed down"	1	2	3	4	5	6	1	2	3	4	5	6
Loss of Appetite	1	2	3	4	5	6	1	2	3	4	5	6
Blurred or double vision	1	2	3	4	5	6	1	2	3	4	5	6
Sensitivity to light	1	2	3	4	5	6	1	2	3	4	5	6

Duration Sum:__________ Severity Sum:______________

Post concussion Assessment/ Re-exam will use the Baseline score as normal for the person being tested.