

## Symptom Checklist

Has the athlete ever had a concussion?	Yes	No	
Was there a loss of consciousness?	Yes	No	Unclear
Does he/she remember the injury?	Yes	No	Unclear
Does he/she have confusion after the injury?	Yes	No	Unclear

### Symptoms observed at time of injury:

Dizziness	Yes	No
Headache	Yes	No
Ringing in Ears	Yes	No
Nausea/Vomiting	Yes	No
Drowsy/Sleepy	Yes	No
Fatigue/Low Energy	Yes	No
“Don’t Feel Right”	Yes	No
Feeling “Dazed”	Yes	No
Seizure	Yes	No
Poor Balance/Coord.	Yes	No
Memory Problems	Yes	No
Loss of Orientation	Yes	No
Blurred Vision	Yes	No
Sensitivity to Light	Yes	No
Vacant Stare/ Sensitivity to Noise	Yes	No
Glassy Eyed	Yes	No

\* Please circle yes or no for each symptom listed above.