# 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 | | Mild | | Moderate | | 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 |
| **Total** | | | | | | | |