East Central Independent School District
Concussion Daily Symptoms Checklist

Athlete Name: _____ **Student ID #** _____ **Grade:** ____ **Date of Injury:** _____

Campus: _____ **Supervising Coach/Nurse/Athletic Trainer:** _____

0	1	2	3	4	5	6
NONE		MILD		MODERATE		SEVERE

NOTE: Grading of symptom severity on a scale 0-6.

	SYMPTOMS	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time
Physical Findings	Headache							
	Pressure in Head							
	Neck Pain							
	Nausea/Vomiting							
	Balance Problems							
	Dizziness							
	Blurred Vision							
	Fatigue/ Low Energy							
	Sensitivity to Light							
	Sensitivity to Noise							
Cognitive Findings	Feeling slowed down							
	Feeling like “in a fog”							
	“Don’t Feel Right”							
	Difficulty concentrating							
	Difficulty remembering							
Emotional Findings	Confusion							
	Nervous or Anxious							
	More Emotional							
	Irritability							
	Sadness							
Sleep Findings	Drowsiness							
	Trouble falling asleep							
Number of Symptoms/Severity								