

Acute Concussion Evaluation

Name:

NHI:

Date of assessment:

Since the injury, has the child/adolescent experienced any of these symptoms any more than usual, over the past 24 hours?

Indicate presence of each symptom (0=No, 1=Yes).

Physical:		Cognitive:		Sleep:	
Headache		Feeling mentally foggy		Drowsiness	
Nausea		Feeling slowed down		Sleeping less than usual	
Vomiting		Difficulty concentrating		Sleeping more than usual	
Balance problems		Difficulty remembering		Trouble falling asleep	
Dizziness					
Visual problems		Emotional:			
Fatigue		Irritability			
Sensitivity to light		Sadness			
Sensitivity to noise		More emotional			
Numbness/tingling		Nervousness			
Total symptom score					/ 22

Child/young person Participation: Full Partial None

Reason for Partial/None: Young Age Confused Inattentive Low arousal
Emotional Upset In Pain Other