Traumatic Brain Injury & Post Concussion Syndrome

Symptom Survey

Initial Exam Date: _____ Current Exam Date: _____

Initial Subjective Score: _____ Post Subjective Score: _____

(Please fill out information <u>below</u> here)

Patient: _____

Age: _____ Date of Injury: _____

Cause of Injury: _____

Location of Head injury: _____

#1 Symptom: _____

#2 Symptom:_____

	Never					Constant/Always
Blurry Vision in the distance	0	1	2	3	4	5
Blurry Vision when reading	0	1	2	3	4	5
Fluctuating/inconsistant vision	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Photophobia (light sensitivity)	0	1	2	3	4	5
Phonophobia (hearing sensitivity)	0	1	2	3	4	5
Double vision	0	1	2	3	4	5
Loses place while reading	0	1	2	3	4	5
Words appear to run together when reading	0	1	2	3	4	5
Poor Memory, forgetful	0	1	2	3	4	5
Attention/Concentration difficulties	0	1	2	3	4	5
Visual memory difficulty	0	1	2	3	4	5
Vision is worse at the end of the day	0	1	2	3	4	5
Rereads reading material in order to comprehend	0	1	2	3	4	5
Difficulty with eye tracking	0	1	2	3	4	5
Eye fatigue	0	1	2	3	4	5
Mental fatigue	0	1	2	3	4	5
Physical fatigue	0	1	2	3	4	5
Spatial disorientation	0	1	2	3	4	5
Night vision worse than day vision	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Flashes of light	0	1	2	3	4	5
Irratability	0	1	2	3	4	5
Emotional distress/anxiety	0	1	2	3	4	5
Balance issues	0	1	2	3	4	5
Vertigo/Nausea	0	1	2	3	4	5
Car/motion sickness	0	1	2	3	4	5
Sleep disturbances	0	1	2	3	4	5
Disordered thinking	0	1	2	3	4	5
Walking difficulties	0	1	2	3	4	5
Poor depth perception	0	1	2	3	4	5

Total Score: _____