Ascension Medical Group-Orthopaedics & Sports Medicine
Concussion Symptom Tracker

☐Baseline ☐Post-Injury

Patient Name:_____ Date Completed:_____ **(AM / PM)**

Date of Injury: _____ Post Injury Day Number: #_____

Symptom	None	Mild	Mild	Moderate	Moderate	Severe	Severe
Headache	**0**	**1**	**2**	**3**	**4**	**5**	**6**
Pressure in Head							
Neck Pain							
Nausea/Vomiting							
Dizziness							
Blurred Vision							
Balance Issues							
Light Sensitivity							
Noise Sensitivity							
Feeling Slowed Down							
Feeling "in a fog"							
Don't Feel Right							
Difficulty Concentrating							
Difficulty Remembering							
Fatigue / Low Energy							
Confusion							
Drowsiness							
More Emotional							
Irritability							
Sadness							
Nervous / Anxious							
Trouble falling asleep							

Total Number of Symptoms	**____ Of 22**
Symptom Severity Score	**____ Of 132**
Worse with physical activity	**Yes or No**
Worse with mental activity	**Yes or No**
If 100% is feeling perfectly normal, what do % do you feel?	**_____ %**

To better track your recovery please complete this log daily in the morning and in the evening at approximately the same time (example: before school & after school). If your institution has a Certified Athletic Trainer, present this documentation to him/her. If your school does not have a Certified Athletic Trainer save the completed form or a picture of the completed form and email it to the Sports Medicine team at : **donotreply_amg_saginawsports@ascension.org** for further direction on the next steps for Return To Play.

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