Symptom Evaluation
Concussion/Traumatic Brain Injury
(from SCAT 5)

☐ If not applicable, please check this box and skip this page.

SCORE: Choose a whole number per symptom.

0 1 2 3 4 5 6

None **Severe**

Symptom	SCORE
Headache	
"Pressure in head"	
Neck Pain	
Nausea or Vomiting	
Dizziness	
Blurred Vision	
Balance problems	
Sensitivity to light	
Sensitivity to noise	
Feeling slowed down	
Feeling like "in a fog"	
"Don't feel right"	
Difficulty concentrating	
Difficulty remembering	
Fatigue or low energy	
Confusion	
Drowsiness	
Trouble falling asleep	
More emotional	
Irritability	
Sadness	
Nervous or Anxious	
OFFICE USE ONLY BELOW THIS LINE	STOP HERE
Total # of symptoms	
Symptom Severity Score	

Name: _____

DOB: _____

Date: _____

OFFICE USE ONLY

Previous Test ☐ N/A

Date: _____

Total # of Symptoms: _____

Symptom Severity: _____

PHYSICAL EXAMINATION