Daily Concussion Self-Assessment Checklist

First Name

Last Name

Grade / Year

Sport

For Athletic Trainer Only

Headache in last 24 hours

0 1 2 3 4 5 6

Dizziness in past 24 hours

0 1 2 3 4 5 6

Feeling mentally foggy

0 1 2 3 4 5 6

Nausea in past 24 hours

0 1 2 3 4 5 6

Auditory Sensitivity (loud noise, halls, gym, band, choir)

0 1 2 3 4 5 6

Photosensitivity (bright lights, computer, projector)

0 1 2 3 4 5 6

Difficulty remembering

0 1 2 3 4 5 6

Inability to focus / concentrate

0 1 2 3 4 5 6

Increased processing speed (takes longer to read)

- **Create a Google form for each student**
  - **make copy of original form**
  - **rename with student's name/ID info**
- **Student completes form (or nurse if student is unable**
- **Google spreadsheet (Responses)**
  - **file in student health record**
  - **share with physicians**

Feeling slowed down / things moving in slow motion

0 1 2 3 4 5 6

Feeling more sad, irritable, don't "feel right"

0 1 2 3 4 5 6

Sleeping more than usual

0 1 2 3 4 5 6

Sleeping less than usual

0 1 2 3 4 5 6

Difficulty sleeping

0 1 2 3 4 5 6

Comments

Submit

Never submit passwords through Google Forms.