Concussion Symptom Checklist

Use this checklist to help evaluate a suspected concussion. This for may be completed by a coach during or after gameplay or practice; or by a parent after a head injury has occurred.

Player Name:	**Date of Injury:**	**Today's Date/Time:**
Location/Rink of Injury:	**Team/Coach:**	**Name/Contact of Person Completing Form:**

Symptom	Yes	No	Notes
Headache	☐	☐	
"Pressure in head"	☐	☐	
Neck pain	☐	☐	
Balance problems or dizzy	☐	☐	
Nausea or vomiting	☐	☐	
Visual problems (double or blurred vision, etc.)	☐	☐	
Hearing problems/ringing	☐	☐	
"Don't feel right"	☐	☐	
Feeling "dinged" or "dazed"	☐	☐	
Confusion	☐	☐	
Feeling slowed down	☐	☐	
Feeling like "in a fog"	☐	☐	
Drowsiness	☐	☐	
Fatigue or low energy	☐	☐	
Feeling more emotional	☐	☐	
Irritability	☐	☐	
Difficulty concentrating	☐	☐	
Difficulty remembering	☐	☐	
sadness	☐	☐	
Nervousness or anxious	☐	☐	
Sensitivity to light	☐	☐	
Sensitivity to noise	☐	☐	
Previous Concussion(s)	☐	☐	*If yes, how many?