Post-Concussion Symptom Scale (PCSS)

Intermountain Health

Name: _____ DOB: _____ Date: _____

Instructions: For each item, indicate how much the symptom has bothered you over the past 2 days.

	Symptoms	None	Mild		Moderate		Severe	
Physical	1 Headache	0	1	2	3	4	5	6
	2 Nausea	0	1	2	3	4	5	6
	3 Vomiting	0	1	2	3	4	5	6
	4 Balance problems	0	1	2	3	4	5	6
	5 Dizziness	0	1	2	3	4	5	6
	6 Fatigue	0	1	2	3	4	5	6
	7 Sensitivity to light	0	1	2	3	4	5	6
	8 Sensitivity to noise	0	1	2	3	4	5	6
	9 Numbness/Tingling	0	1	2	3	4	5	6
Thinking	10 Feeling mentally foggy	0	1	2	3	4	5	6
	11 Feeling slowed down	0	1	2	3	4	5	6
	12 Difficulty concentrating	0	1	2	3	4	5	6
	13 Difficulty remembering	0	1	2	3	4	5	6
Sleep	14 Drowsiness	0	1	2	3	4	5	6
	15 Sleeping less than usual	0	1	2	3	4	5	6
	16 Sleeping more than usual	0	1	2	3	4	5	6
	17 Trouble falling asleep	0	1	2	3	4	5	6
Emotional	18 Irritability	0	1	2	3	4	5	6
	19 Sadness	0	1	2	3	4	5	6
	20 Nervousness	0	1	2	3	4	5	6
	21 Feeling more emotional	0	1	2	3	4	5	6
	TOTAL____/126							

Do you have any visual problems? Yes No

Do these symptoms worsen with:

- Physical Activity Yes No Not applicable
- Thinking/Cognitive Activity Yes No Not applicable

Over the past 2 days, my daily activity level has been ____% of normal.

If "YES" to any visual problems, further qualify with the Convergence Insufficiency Symptom Survey.

Permission from Wolters Kluwer; Lovell and Collins, *Journal of Head Trauma and Rehabilitation* 1998;13:9-26. Baseline levels should be taken and compared.