

King Philip Regional High School – New Head Injury Symptom Severity Scale Form

Last Name: _____ First Name: _____ Date: ____/____/____

Teacher: _____ Class: _____ Time: ____:____ AM / PM

STEP 1: RED FLAGS

If there is concern after an injury including whether ANY of the following signs are observed or complaints are reported, then the student should be safely and immediately removed from play/game/activity:

- _____ Neck pain or tenderness _____ Severe or increasing headache
- _____ Double vision _____ Seizure or convulsions
- _____ Loss of consciousness _____ Vomiting
- _____ Deteriorating conscious state
- _____ Weakness/tingling/burning in arms/legs
- _____ Increasingly restless, agitated, or combative

STEP 4: MECHANISM OF INJURY

HAVE STUDENT WRITE WHAT HAPPENED

STEP 2: HAVE STUDENT READ TEXT ALOUD

The symptom severity scale should be completed by the student, not by the examiner. The student should be given the symptom form and asked to read this instruction paragraph aloud then complete the symptom severity scale. In situations where the symptom scale is being completed after exercise, it should be done in a resting state, generally by approximating his/her resting heart rate. The student should rate their symptoms and the following questions to the best of their ability at this point in time and then hand the sheet back to the examiner.

AFTER COMPLETING STEP 4, HAVE THE STUDENT WAIT AT MINIMUM 20 MINUTES AS SIGNS AND SYMPTOMS CAN CHANGE, EITHER DEVELOPING, WORSENING, OR SUBSIDING.

STEP 5: SECOND SYMPTOM SEVERITY SCALE

Time: ____:____ AM / PM

STEP 3: FIRST SYMPTOM SEVERITY SCALE

Time: ____:____ AM / PM

Symptom	None	Mild	Moderate	Severe			
Headache	0	1	2	3	4	5	6
Pressure in Head	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or Vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred Vision	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Sensitivity to Light	0	1	2	3	4	5	6
Sensitivity to Noise	0	1	2	3	4	5	6
Feeling Slowed Down	0	1	2	3	4	5	6
Feeling Like "In A Fog"	0	1	2	3	4	5	6
Don't Feel Right	0	1	2	3	4	5	6
Difficulty Concentrating	0	1	2	3	4	5	6
Difficulty Remembering	0	1	2	3	4	5	6
Fatigue or Low Energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble Falling Asleep	0	1	2	3	4	5	6
More Emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6

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Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6

Total Number of Symptoms ____ / 22

Symptoms Severity Score ____ / 132

If 100% Is Normal, What Percent of Normal Do You Feel? _____%

Why? _____

Do Your Symptoms Get Worse with Physical Activity? Y N

Do Your Symptoms Get Worse with Mental Activity? Y N

Total Number of Symptoms ____ / 22

Symptoms Severity Score ____ / 132

If 100% Is Normal, What Percent of Normal Do You Feel? _____%

Why? _____

Do Your Symptoms Get Worse with Physical Activity? Y N

Do Your Symptoms Get Worse with Mental Activity? Y N

EXAMINER'S NOTES:
