ACTIVATE
Brain Clinic & Chiropractic

Concussion Questionnaire

Date of Injury:_____

Please use the following scale to rate your symptoms.

0 = Never Experienced
1 = Sometimes
2 = Often
3 = Constant
R = Resolved

Dizziness	0	1	2	3	R
Headaches	0	1	2	3	R
Hearing Changes	0	1	2	3	R
Vision Changes	0	1	2	3	R
Balance Changes	0	1	2	3	R
Nausea and/ or Vomiting	0	1	2	3	R
Light Sensitivity, bothered by bright light	0	1	2	3	R
Noise Sensitivity, bothered by loud noise	0	1	2	3	R
Sleep disturbances	0	1	2	3	R
Fatigue, tiring more easily	0	1	2	3	R
Being Irritable, easily angered	0	1	2	3	R
Feeling Depressed or Tearful	0	1	2	3	R
Feeling Anxious or Tense	0	1	2	3	R
Poor memory	0	1	2	3	R
Poor Concentration	0	1	2	3	R
Feeling Mentally Foggy	0	1	2	3	R

If you circled *Any* 1-3 Contact Activate Brain Clinic
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