Abingdon- Avon CUSD 276
Head Injury Symptom Scale

Patient: After reading each symptom, please circle the number which best describes the way you have been feeling **today**. A rating of **0** means you have **not** experienced this symptom today. A rating of **6** means you have experienced **severe** problems with this symptom today. Then, answer the questions at the bottom of the form.

Clinician: Review, sign, and scan into student's IHP for record keeping/tracking.

	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 (If Applicable)	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

Total Number of Symptoms: _____ Symptom severity score: _____ of 132

Do your symptoms get worse w/ physical activity? Y / N?

Do your symptoms get worse with mental activity? Y / N?

If 100% is feeling perfectly normal, what percent of normal do you feel? _____

Clinician Signature: _____

Abingdon- Avon CUSD 276
Head Injury Symptom Scale

Recommendations for School Following a Concussion

Student Name: _____ Date of Evaluation: _____
Provider Name: _____ Date of Concussion: _____

School Recommendations
__ Student has no academic restrictions
__ Student is cleared for full activity
__ Please note the recommendations prescribed below

Breaks
__Allow Student to go to the nurses office as needed
__ Student may go home if symptoms do not subside

Attendance
__ No school for ____ school day(s)
__ No school until symptoms free or significant
__ Part time attendance for _____ school day(s) as tolerated
__ Full school days as tolerated

Workload/Multi-Tasking
__ No homework
__ Limit homework to ____ minutes a night
__ Reduce overall work to essential learning
__ Prorate workload when possible

Visual Stimulus
__ Allow student to wear sunglasses/hat in school
__ Pre-printed notes for class materials or notetaker
__ Limit screen use, i.e. computer, TV, phone
__ Change classroom seating as needed
__ Reduce brightness on monitors/ screens

Testing/ Project
__ No testing/ projects
__ No more than one test per day
__ Extra time to complete tests
__ Allow for scribe or oral testing

Physical Exertion
__ No physical exertion/ athletics/ PE/ recess
__ Light aerobic activity only
__ Non-contact/non collision activity only
__ Begin return to play protocol prior to participating in PE or athletics

Audible Stimulus
__ Allow class transitions before end of class
__ Lunch in a quiet location
__ Avoid music/band or shop class
__ Audible Learning

Follow Up Date: _____

Additional Recommendations: _____
_____
_____
_____

Medical Provider's Signature: _____