Name: _____ **Date:**_____ **Time:** _____

How have you been feeling recently? Please check the appropriate column rating the symptom from 0 to 6 as indicated.

Symptom	**0** Not at all	**1** Slight	**2** Mild	**3** Mild to Moderate	**4** Moderate	**5** Severe	**6** Extreme
Headache	◯	◯	◯	◯	◯	◯	◯
Nausea	◯	◯	◯	◯	◯	◯	◯
Vomiting	◯	◯	◯	◯	◯	◯	◯
Balance problems	◯	◯	◯	◯	◯	◯	◯
Dizziness	◯	◯	◯	◯	◯	◯	◯
Double vision/blurry vision	◯	◯	◯	◯	◯	◯	◯
Fatigue	◯	◯	◯	◯	◯	◯	◯
Trouble falling asleep	◯	◯	◯	◯	◯	◯	◯
Sleeping more than usual	◯	◯	◯	◯	◯	◯	◯
Sleeping less than usual	◯	◯	◯	◯	◯	◯	◯
Drowsiness/sleepiness	◯	◯	◯	◯	◯	◯	◯
Sensitivity to light	◯	◯	◯	◯	◯	◯	◯
Sensitivity to noise	◯	◯	◯	◯	◯	◯	◯
Irritability	◯	◯	◯	◯	◯	◯	◯
Sadness	◯	◯	◯	◯	◯	◯	◯
Nervousness	◯	◯	◯	◯	◯	◯	◯
Feeling more emotional	◯	◯	◯	◯	◯	◯	◯
Feeling slowed down	◯	◯	◯	◯	◯	◯	◯
Feeling mentally foggy	◯	◯	◯	◯	◯	◯	◯
Difficulty concentrating	◯	◯	◯	◯	◯	◯	◯
Difficulty with memory	◯	◯	◯	◯	◯	◯	◯
Neck pain or stiffness	◯	◯	◯	◯	◯	◯	◯
Numbness/tingling	◯	◯	◯	◯	◯	◯	◯

Do you have a headache right now? ◯ Y ◯ N How bad is it from 1-6? _____

Hours of sleep last night_____ Last dose of pain medication_____

Comments