

Post-Concussion Symptom Scale (PCSS)

Rate how much each symptom has bothered you over the last 48 hours.

Name: _____ Date: _____ Date of injury: _____

Circle one number per row. 0 = none 1-2 = mild 3-4 = moderate 5-6 = severe

Symptom	0	1	2	3	4	5	6
Headache	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Fatigue	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
Sleeping more than usual	0	1	2	3	4	5	6
Sleeping less than usual	0	1	2	3	4	5	6
Drowsiness	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
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6
Feeling more emotional	0	1	2	3	4	5	6
Numbness or tingling	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling mentally foggy	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
Visual problems	0	1	2	3	4	5	6

Total (add all 22 numbers, 0 to 132): _____

There is no single cutoff that confirms a concussion. Clinicians read the total alongside time since injury, the person's usual baseline and how symptoms change over time. Bring this sheet to your appointment.

PCSS tracking sheet

Rate each symptom 0 to 6 on each date. Watching the total over time shows how recovery is going.

Name: _____ Date of injury: _____

Symptom	Date /	Date /	Date /	Date /	Date /	Date /
Headache						
Nausea						
Vomiting						
Balance problems						
Dizziness						
Fatigue						
Trouble falling asleep						
Sleeping more than usual						
Sleeping less than usual						
Drowsiness						
Sensitivity to light						
Sensitivity to noise						
Irritability						
Sadness						
Nervousness						
Feeling more emotional						
Numbness or tingling						
Feeling slowed down						
Feeling mentally foggy						
Difficulty concentrating						
Difficulty remembering						
Visual problems						
TOTAL						