Summary Sheet: Brain Health Symptom Inventory

Name:	**Email:**
Current Date:	**Date of last injury:**

Using the Brain Health Symptom Inventory, track your progress below. For the date, put the number 0-6 on the proper line and place. Total the 22 numbers at the bottom.

0 None: Rarely if ever present. Not a concern.

1-2 Mild: Occasionally present, but does really not disrupt activities. A little concern for me.

3-4 Moderate: Often present, disrupts activities, but still function. Can't do complicated tasks or activities. I am concerned.

5-6 Severe: Frequently to almost always present and disrupts activities. Cannot function without help. I'm very concerned.

DATE:								
Headaches								
Feeling dizzy, loss of balance, coordination problems								
Vision problems, blurring, trouble seeing								
Sensitivity to light								
Hearing difficulty, sensitivity to noise								
Ringing in the ears								
Change in taste and/or smell								
Not able to think clearly, feeling mentally "foggy"								
Problems with confusion, easily confused								
Feeling depressed or sad								
Emotional withdrawal								
Feeling anxious or tense, nervousness								
Irritability, easily annoyed, temper outbursts, hostility								
Feeling easily overwhelmed by things								
Feeling more emotional								
Fatigue, loss of energy, getting tired easily, drowsiness								
Difficulty concentrating, can’t pay attention, easily distracted								
Difficulty remembering things, forgetfulness, memory concerns								
Difficulty making decisions								
Difficulty reading								
Insomnia; difficulty falling or staying asleep								
Libido issues/concerns with desire or functioning								
TOTAL SCORE IN THIS COLUMN:								
OVERALL, I FEEL ___% OUT OF 100%:								

This form is informational only. It is not intended to diagnose or treat any condition or disease. If you have any concerns about your scores or your recovery following a concussion, TBI, or head injury, please contact your healthcare provider.

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