

NAME: _____

DATE: _____

RIVERMEAD POST CONCUSSION SYMPTOMS QUESTIONNAIRE

After a head injury or accident some people experience symptoms that can cause worry or nuisance. We would like to know if you suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below please circle the number that most closely represents your answer.

- 0 = not experienced at all
 1 = no more of a problem
 2 = a mild problem
 3 = a moderate problem
 4 = a severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

	Not experienced	No more of a problem	Mild problem	Moderate problem	Severe problem
1. Headaches	0	1	2	3	4
2. Feelings of dizziness	0	1	2	3	4
3. Nausea and/or vomiting	0	1	2	3	4
4. Noise sensitivity (easily upset by loud noise)	0	1	2	3	4
5. Sleep disturbance	0	1	2	3	4
6. Fatigue, tiring more easily	0	1	2	3	4
7. Being irritable, easily angered	0	1	2	3	4
8. Feeling depressed or tearful	0	1	2	3	4
9. Feeling frustrated or impatient	0	1	2	3	4
10. Forgetfulness, poor memory	0	1	2	3	4
11. Poor concentration	0	1	2	3	4
12. Taking longer to think	0	1	2	3	4
13. Blurred vision	0	1	2	3	4
14. Light sensitivity (easily upset by bright light)	0	1	2	3	4
15. Double vision	0	1	2	3	4
16. Restlessness	0	1	2	3	4

Are you experiencing any other difficulties? Please specify, and rate as above.

17. _____ 0 1 2 3 4

18. _____ 0 1 2 3 4