Post-Concussion Symptom Inventory (PCSI-P)
Baseline Assessment Report
Child Self-Report Assessment Form

Student's Name:_____ **Today's date:** _____
Birthdate:_____ **Age/ Grade:**_____

Instructions: We would like to know if you have had any of these symptoms over the past day.
Please tell us how much of a problem each symptom has been for you by circling one number on a scale from zero (not a problem) to six (severe problem). Please answer all of the items the best that you can. Do not skip any items.

0 = Not a problem 3 = Moderate problem 6 = Severe problem

1	Complained of headaches	0 1 2 3 4 5 6
2	Complained of nausea	0 1 2 3 4 5 6
3	Vomited	0 1 2 3 4 5 6
4	Had balance problems	0 1 2 3 4 5 6
5	Appeared or complained of dizziness	0 1 2 3 4 5 6
6	Had trouble falling asleep	0 1 2 3 4 5 6
7	Was sleeping more than usual	0 1 2 3 4 5 6
8	Was sleeping less than usual	0 1 2 3 4 5 6
9	Appeared drowsy	0 1 2 3 4 5 6
10	Was sensitive to light	0 1 2 3 4 5 6
11	Was sensitive to noise	0 1 2 3 4 5 6
12	Was irritable	0 1 2 3 4 5 6
13	Appeared sad	0 1 2 3 4 5 6
14	Acted nervous	0 1 2 3 4 5 6
15	Acted more emotional	0 1 2 3 4 5 6
16	Had or complained of numbness or tingling	0 1 2 3 4 5 6
17	Acted or appeared slowed down	0 1 2 3 4 5 6
18	Acted or appeared mentally "foggy"	0 1 2 3 4 5 6
19	Had difficulty concentrating	0 1 2 3 4 5 6
20	Had difficulty remembering	0 1 2 3 4 5 6
21	Had or complained of visual problems (blurry, double vision)	0 1 2 3 4 5 6
22	Appeared more tired or fatigued	0 1 2 3 4 5 6
23	Appeared dazed or stunned	0 1 2 3 4 5 6

24	Became confused with directions or tasks	0 1 2 3 4 5 6
25	Appeared to move in a clumsy manner	0 1 2 3 4 5 6
26	Answered questions more slowly than usual	0 1 2 3 4 5 6