De Leon Independent School District
Current Symptoms and Conditions

Name:_____ Date:_____

Date of Last Concussion:_____(Month – Day – Year)

Total Hours of Sleep Last Night:_____

Current Medications:_____

Check the box below indicates symptoms you are CURRENTLY experiencing.

- Headache ☐
- Nausea ☐
- Vomiting ☐
- Balance Problems ☐
- Dizziness ☐
- Fatigue ☐
- Trouble Falling Asleep ☐
- Excessive Sleep ☐
- Loss of Sleep ☐
- Drowsiness ☐
- Light Sensitivity ☐
- Noise Sensitivity ☐
- Irritability ☐
- Sadness ☐
- Nervousness ☐
- More Emotional ☐
- Numbness ☐
- Feeling “Foggy” ☐
- Feeling “Slow” ☐
- Difficulty Concentrating ☐
- Difficulty Remembering ☐
- Visual Problems ☐