BlueSky NEUROLOGY

SYMPTOM SCALE

Follow Up

Name: _____ Date: _____ Dr. _____

Score yourself on the duration of the following symptoms throughout the past 24 hours:

		Briefly		Sometimes		Always	
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck pain	0	1	2	3	4	5	6
Nausea/vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Numbness/tingling	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Ringing in ears	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitive to light	0	1	2	3	4	5	6
Sensitive to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
Do not feel right	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
Fatigue/low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
Sleeping more	0	1	2	3	4	5	6
Sleeping less	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritable	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous/anxious	0	1	2	3	4	5	6

TOTAL SCORE: _____