Post-Concussion Symptom Inventory for Children aged 5-7 (PCSI-C)

Name:_____**Today's date:**_____ **DOB:**_____ **Age:**_____ **Gr.**_____

Instructions: We would like to know if you have had any of these symptoms before your injury. Next, we would like to know if these symptoms have changed after your injury.

I am going to ask you to tell me about your symptoms at two points in time- Before the Injury and Yesterday/ Today. Circle one.

	0= No 1= A little 2= A lot	Before the injury			Current Symptoms		
1	Have you had headaches? Has your head hurt?	0	1	2	0	1	2
2	Have you felt sick to your stomach like you were going to throw up?	0	1	2	0	1	2
3	Have you felt like you might fall when you walk, run, or stand?	0	1	2	0	1	2
4	Have you felt dizzy? (like things around you are spinning or moving)	0	1	2	0	1	2
5	Have you felt more tired than usual?	0	1	2	0	1	2
6	Have bright lights bothered you more than usual? (like when you were outside or watched TV)	0	1	2	0	1	2
7	Have loud noises bothered you more than usual? (like when people were talking or listened to loud music)	0	1	2	0	1	2
8	Have you felt grumpy? (like you were in a bad mood)	0	1	2	0	1	2
9	Have you felt sad?	0	1	2	0	1	2
10	Have you felt nervous or worried?	0	1	2	0	1	2
11	Has it been hard for you to pay attention to what you are doing? (Like homework or playing a game)	0	1	2	0	1	2
12	Has it been hard for you to remember things? (like things you heard or saw)	0	1	2	0	1	2
13	Have things looked fuzzy or blurry?	0	1	2	0	1	2
14	Do you feel "different" than usual?				0	1	2

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