Post-Concussion Symptom Inventory for Children aged 8-12 (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. Please rate the symptom at two points in time- Before the injury and Current symptoms.

Please answer all the items the best that you can. Do not skip any items. Circle the number to tell us how much of a problem this symptom has been to you.

	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 or nauseous?	0	1	2	0	1	2
3	Have you had any balance problems or 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 you felt more drowsy or sleepy than usual?	0	1	2	0	1	2
7	Have bright lights bothered you more than usual?	0	1	2	0	1	2
8	Have loud noises bothered you more than usual?	0	1	2	0	1	2
9	Have you felt grumpy or irritable? (like you were in a bad mood)	0	1	2	0	1	2
10	Have you felt sad?	0	1	2	0	1	2
11	Have you felt nervous or worried?	0	1	2	0	1	2
12	Have you felt like you are moving more slowly?	0	1	2	0	1	2
13	Have you felt like you are thinking more slowly?	0	1	2	0	1	2
14	Has it been hard to think clearly?	0	1	2	0	1	2
15	Has it been hard for you to pay attention to what you are doing? Like homework	0	1	2	0	1	2
16	Has it been hard for you to remember things?	0	1	2	0	1	2
17	Have things looked blurry?	0	1	2	0	1	2
18	Do you feel "different" than usual?				0	1	2

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