

Rivermead Post Concussion Symptoms Questionnaire

Name _____ Date _____

After a head injury or accident some people experience problems which can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident.

For each one please circle the number closest to your answer:

- 0 = Have not experienced at all
- 1 = No longer a problem
- 2 = A mild problem
- 3 = A moderate problem
- 4 = A severe problem

Compared with before the accident:

Do you now (i.e., over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred vision	0	1	2	3	4
Light sensitivity, easily upset by bright light	0	1	2	3	4
Double vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

Please specify and rate as above:

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

Rivermead Head Injury Follow-Up Questionnaire

Name _____ Date _____

After a head injury or accident some people experience problems which can cause worry or nuisance. We would like to know if you have difficulties with any of the activities listed below. We would like you to compare yourself now with how you were before the accident/injury.

For each one please circle the number closest to your answer:

- 0 = No change
- 1 = No change, but more difficult
- 2 = A mild change
- 3 = A moderate change
- 4 = A very marked change

Compared with before the accident/injury,

Has there been a change in your:

Ability to participate in conversation with 1 person	0	1	2	3	4
Ability to participate in conversation with 2 or more people	0	1	2	3	4
Performance of routine domestic activities	0	1	2	3	4
Ability to participate in previous social activities	0	1	2	3	4
Ability to enjoy previous leisure activities	0	1	2	3	4
Ability to maintain previous workload	0	1	2	3	4
Finding work more tiring	0	1	2	3	4
Relationship with previous friends	0	1	2	3	4
Relationship with your partner	0	1	2	3	4
Ability to cope with family demands	0	1	2	3	4

Are you experiencing any other difficulties?

Please specify and rate as above:

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

Would you like a follow up appointment for further advice?

YES NO