Dr. Chalfin's Concussion Symptom Questionnaire (mSIT)

Name: _____ Date: _____

DATE OF HEAD INJURY: _____

Please rate how much each symptom is bothering you RIGHT NOW on a scale of 0 to 6, where 0 = Not at all, 1 = A little, and 6 = Severe. Circle one number for each symptom:

Symptom	**Severity**
1. Headache	0 1 2 3 4 5 6
2. Pressure in your head	0 1 2 3 4 5 6
3. You "don't feel right"	0 1 2 3 4 5 6
4. Bothered by bright lights	0 1 2 3 4 5 6
5. Dizziness	0 1 2 3 4 5 6
6. Bothered by loud noises	0 1 2 3 4 5 6
	Total Score _____ / 36

Is there anything else you want your doctor to know about how you are feeling today?

_____

_____

Subtest	**HA**	**Dizz**	**Nau**	**Fog**	**Any ≥2? (Y/N)**
Smooth Pursuits	/10	/10	/10	/10	Y / N
Saccades	/10	/10	/10	/10	Y / N
hVOR	/10	/10	/10	/10	Y / N
VMS	/10	/10	/10	/10	Y / N
Total Score	**/160**		**Positive subtests**		**/4**

OFFICE USE ONLY

Visit Date	**mSIT score (/36)**	**mSIT positive? (≥2)**	**mVOMS Total (/160)**	**mVOMS # pos subtests**	**NPC Avg**	**NPC Abnl? (≥ 5)**