FlightAR

Daily Log

Instructions

Please use this book and fill out each page based on how you are feeling.

If you forget a day that's no worry, just skip that page and move on.

No Symptoms? That's awesome to hear! I have to throw out the data if you don't put 0, please still fill it out.

Feel free to put anything relevant in notes, so any kind of context.

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes:

Date: _____ / _____ / _____ Session? ☐ __ /16. Baseline Day? ☐

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Nausea	0	1	2	3	4	5	6
	Vomiting	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Fatigue	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
	Numbness/Tingling	0	1	2	3	4	5	6
Thinking	Feeling mentally foggy	0	1	2	3	4	5	6
	Feeling Slowed Down	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
Sleep	Drowsiness	0	1	2	3	4	5	6
	Sleeping less than usual	0	1	2	3	4	5	6
	Sleeping more than usual	0	1	2	3	4	5	6
	Trouble Falling Asleep	0	1	2	3	4	5	6
Emotion	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervousness	0	1	2	3	4	5	6
	Feeling more emotional	0	1	2	3	4	5	6

Do you these activities worsen with:

Physical Activity ☐ yes ☐ no ☐ not applicable

Thinking/Cognitive Activity ☐ yes ☐ no ☐ not applicable

My daily activity level has been ___% of normal.

Notes: