VAUGHAN PHYSIOTHERAPY CLINIC

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Scan for your patient portal: book, forms and receipts

Rivermead Post-Concussion Questionnaire

Get better today.

After a head injury or accident some people have symptoms that can cause worry or nuisance. Compared with how you were before the accident, do you now (over the last 24 hours) have any of these symptoms? Rate each one.

Patient name *		**Date of birth ***	Y Y Y Y - M M - D D

Date of injury	Y Y Y Y - M M - D D	**How did it happen?**	

Symptoms over the last 24 hours

0 = not experienced · 1 = no more of a problem than before · 2 = mild · 3 = moderate · 4 = severe

Compared with before the injury, do you have...	0	1	2	3	4
1. Headaches	○	○	○	○	○
2. Feelings of dizziness	○	○	○	○	○
3. Nausea and/or vomiting	○	○	○	○	○
4. Noise sensitivity, easily upset by loud noise	○	○	○	○	○
5. Sleep disturbance	○	○	○	○	○
6. Fatigue, tiring more easily	○	○	○	○	○
7. Being irritable, easily angered	○	○	○	○	○
8. Feeling depressed or tearful	○	○	○	○	○
9. Feeling frustrated or impatient	○	○	○	○	○
10. Forgetfulness, poor memory	○	○	○	○	○
11. Poor concentration	○	○	○	○	○
12. Taking longer to think	○	○	○	○	○
13. Blurred vision	○	○	○	○	○
14. Light sensitivity, easily upset by bright light	○	○	○	○	○
15. Double vision	○	○	○	○	○
16. Restlessness	○	○	○	○	○

Any other difficulties? Please describe and rate (0 to 4)	

Signature *		**Date ***	Y Y Y Y - M M - D D

Office use: RPQ-3 / RPQ-13 scores		**Reviewed by**	