

Patient Activity Guidance After Concussion

Stage 1: Rest

If your symptoms get worse or you have new symptoms, stop the activity immediately and tell your provider.

Physical Activities

- rest
- sleep (6-8 hrs at night, daytime naps as needed)
- wear comfortable clothes
- sit down if you feel you need to while showering or dressing
- walk at an easy pace for short distances (bathroom, meals)
- pay attention to whether you are holding your breath when you bend over or are under stress — do not hold your breath or grunt

Thinking/Decision Activities

- rest in a quiet environment with low lighting
- wear your corrective lenses and sunglasses if needed
- periods of television with rest breaks each hour



Body Movement/Balance Activities

- limit positions where your head is below your heart
- pay attention to head movements that cause symptoms
- put your shoes on by bringing your foot to your knee rather than bending with your head down



AVOID

- caffeine
- tobacco products

DO NOT!!!

- work or study
- drink alcohol
- exercise
- drive
- exert yourself to the point of making your heart race
- play video games

Write in your:

• Resting HR ____

• Active HR ____

Max Heart Rate	
Age	40%
15	82
20	80
25	78
30	76
35	74
40	72
45	70
50	68
55	66
60	64
65	62

220-Age=100% HR



Practice good sleep habits (get 6-8 hours). See Healthy Sleep fact sheet at dvbic.dcoe.mil.

Please complete the Symptom Report on the back of this form before you see your provider.

PATIENTS

Patient Name: _____

ID#: _____

Date of Evaluation: _____

Date of Injury: _____

Symptom Report

Please rate the following symptoms **before** you see your health care provider. Please **DO NOT** attempt to score.

- 0 None** - Rarely if ever present; not a problem at all.
- 1 Mild** - Occasionally present, but it does not disrupt my activities. I can usually continue what I'm doing; doesn't really concern me.
- 2 Moderate** - Often present, occasionally disrupts my activities. I can usually continue what I'm doing with some effort. I feel somewhat concerned.
- 3 Severe** - Frequently present and disrupts activities. I can only do things that are fairly simple or take little effort. I feel I need help.
- 4 Very Severe** - Almost always present and I have been unable to perform at work, school or home due to this problem. I probably cannot function without help.

Handouts provided: _____

Symptoms

Feeling dizzy	0	1	2	3	4
Loss of balance	0	1	2	3	4
Poor coordination, clumsy	0	1	2	3	4
Headaches	0	1	2	3	4
Nausea	0	1	2	3	4
Vision problems, blurring, trouble seeing	0	1	2	3	4
Sensitivity to light	0	1	2	3	4
Hearing difficulty	0	1	2	3	4
Sensitivity to noise	0	1	2	3	4
Numbness or tingling on parts of my body	0	1	2	3	4
Change in taste and/or smell	0	1	2	3	4
Loss of appetite or increased appetite	0	1	2	3	4
Poor concentration, can't pay attention, easily distracted	0	1	2	3	4
Forgetfulness, can't remember things	0	1	2	3	4
Difficulty making decisions	0	1	2	3	4
Slowed thinking, difficulty getting organized, can't finish things	0	1	2	3	4
Fatigue, loss of energy, getting tired easily	0	1	2	3	4
Difficulty falling or staying asleep	0	1	2	3	4
Feeling anxious or tense	0	1	2	3	4
Feeling depressed or sad	0	1	2	3	4
Irritability, easily annoyed	0	1	2	3	4
Poor frustration tolerance, feeling easily overwhelmed by things	0	1	2	3	4

Neurobehavioral Symptom Inventory (NSI)
Used with permission: Cicerone, KD. J Head Tr Rehabil 1995;10(3):1-17.

Patient Activity Guidance After Concussion

Stage 2: Light Routine Activity

If your symptoms get worse or you have new symptoms, stop the activity immediately and tell your provider.



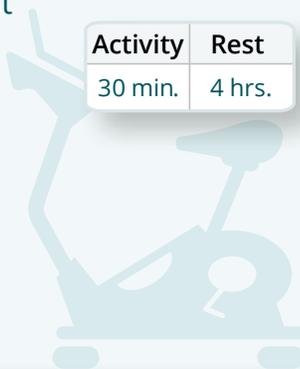
If your resting heart rate is over 100, do not exercise.

Write in your:

- Resting HR _____
- Active HR _____

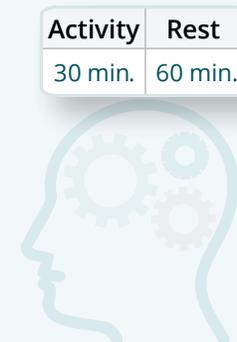
Physical Activities

- limit to 30 minutes followed by a minimum of four hours of rest
- may wear uniform/boots
- stretch
- walk on level surfaces
- take a light ride on a stationary bike (lowest tension setting)



Thinking/Decision-making Activities

- limit to 30 minutes followed by 60 minutes of rest
- do light housework
- read a magazine or newspaper
- use the computer to send email or surf the Internet
- play cards or a simple board game
- assemble, disassemble or clean your weapon



Body Movement/Balance Activities

- increase the amount and speed of head and body movements in your daily routine, such as turning and tilting
- take the stairs
- bend to do things, such as make your bed or pick things up off the floor
- put your shoes on with your feet on the floor
- toss and catch a small foam ball
- change your focus: look far away, nearby, right to left



AVOID

- caffeine
- tobacco products
- crowded areas

DO NOT!!!

- drink alcohol
- drive
- play video games
- do resistance training or repetitive lifting
- do sit-ups, push-ups or pull-ups

Max Heart Rate	
Age	55%
15	114
20	108
25	107
30	104
35	101
40	99
45	96
50	93
55	91
60	88
65	85

220-Age=100% HR



Practice good sleep habits (get 6-8 hours). See Healthy Sleep fact sheet at dvbic.dcoe.mil.

Please complete the Symptom Report on the back of this form before you see your provider.

PATIENTS

Patient Name: _____

ID#: _____

Date of Evaluation: _____

Date of Injury: _____

Symptom Report

Please rate the following symptoms **before** you see your health care provider. Please **DO NOT** attempt to score.

- 0 None** - Rarely if ever present; not a problem at all.
- 1 Mild** - Occasionally present, but it does not disrupt my activities. I can usually continue what I'm doing; doesn't really concern me.
- 2 Moderate** - Often present, occasionally disrupts my activities. I can usually continue what I'm doing with some effort. I feel somewhat concerned.
- 3 Severe** - Frequently present and disrupts activities. I can only do things that are fairly simple or take little effort. I feel I need help.
- 4 Very Severe** - Almost always present and I have been unable to perform at work, school or home due to this problem. I probably cannot function without help.

Handouts provided: _____

Symptoms					
Feeling dizzy	0	1	2	3	4
Loss of balance	0	1	2	3	4
Poor coordination, clumsy	0	1	2	3	4
Headaches	0	1	2	3	4
Nausea	0	1	2	3	4
Vision problems, blurring, trouble seeing	0	1	2	3	4
Sensitivity to light	0	1	2	3	4
Hearing difficulty	0	1	2	3	4
Sensitivity to noise	0	1	2	3	4
Numbness or tingling on parts of my body	0	1	2	3	4
Change in taste and/or smell	0	1	2	3	4
Loss of appetite or increased appetite	0	1	2	3	4
Poor concentration, can't pay attention, easily distracted	0	1	2	3	4
Forgetfulness, can't remember things	0	1	2	3	4
Difficulty making decisions	0	1	2	3	4
Slowed thinking, difficulty getting organized, can't finish things	0	1	2	3	4
Fatigue, loss of energy, getting tired easily	0	1	2	3	4
Difficulty falling or staying asleep	0	1	2	3	4
Feeling anxious or tense	0	1	2	3	4
Feeling depressed or sad	0	1	2	3	4
Irritability, easily annoyed	0	1	2	3	4
Poor frustration tolerance, feeling easily overwhelmed by things	0	1	2	3	4

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Patient Activity Guidance After Concussion

Stage 3: Light Occupation-oriented Activity

If your symptoms get worse or you have new symptoms, stop the activity immediately and tell your provider.



If your resting heart rate is over 100, do not exercise.

Write in your:

- Resting HR _____
- Active HR _____

Max Heart Rate	
Age	65%
15	133
20	130
25	126
30	123
35	120
40	117
45	113
50	110
55	107
60	104
65	100

220-Age=100% HR

Physical Activities

- limit to 60 minutes total, followed by rest
- lift and carry light objects (less than 20 pounds)
- wear helmet and equipment
- perform light military tasks
- take a brisk walk
- use an elliptical machine or stair climber
- do sit-ups, pull-ups, push-ups, planks (no more than 25% of your normal number of reps)

Activity	Rest
60 min.	4 hrs.

Thinking/Decision-making Activities

- limit to 30 minutes followed by 60 minutes of rest
- shop for one item at the store
- talk to someone about what you see as you walk
- follow simple directions to put something together
- gently increase your exposure to light and noise
- do a maintenance check on a vehicle (or other familiar task)

Activity	Rest
30 min.	60 min.

Body Movement/Balance Activities

- walk on uneven terrain or steps, or in a narrow aisle or hallway
- walk in different lighting conditions
- ride in a car as a passenger, and switch your focus from near to distant landmarks
- toss and catch a small foam ball overhead
- stand on one foot with your eyes open, then closed; repeat on the other foot
- do a squat bender, plank or windmill
- swim, but avoid flip turns

AVOID

- caffeine
- tobacco products
- repetitive lifting

DO NOT!!!

- drink alcohol
- drive
- play video games
- participate in combatives or collision sports



Practice good sleep habits (get 6-8 hours). See Healthy Sleep fact sheet at dvbic.dcoe.mil.

Please complete the Symptom Report on the back of this form before you see your provider.

PATIENTS

Patient Name: _____

ID#: _____

Date of Evaluation: _____

Date of Injury: _____

Symptom Report

Please rate the following symptoms **before** you see your health care provider. Please **DO NOT** attempt to score.

- 0 None** - Rarely if ever present; not a problem at all.
- 1 Mild** - Occasionally present, but it does not disrupt my activities. I can usually continue what I'm doing; doesn't really concern me.
- 2 Moderate** - Often present, occasionally disrupts my activities. I can usually continue what I'm doing with some effort. I feel somewhat concerned.
- 3 Severe** - Frequently present and disrupts activities. I can only do things that are fairly simple or take little effort. I feel I need help.
- 4 Very Severe** - Almost always present and I have been unable to perform at work, school or home due to this problem. I probably cannot function without help.

Handouts provided: _____

Symptoms

Feeling dizzy	0	1	2	3	4
Loss of balance	0	1	2	3	4
Poor coordination, clumsy	0	1	2	3	4
Headaches	0	1	2	3	4
Nausea	0	1	2	3	4
Vision problems, blurring, trouble seeing	0	1	2	3	4
Sensitivity to light	0	1	2	3	4
Hearing difficulty	0	1	2	3	4
Sensitivity to noise	0	1	2	3	4
Numbness or tingling on parts of my body	0	1	2	3	4
Change in taste and/or smell	0	1	2	3	4
Loss of appetite or increased appetite	0	1	2	3	4
Poor concentration, can't pay attention, easily distracted	0	1	2	3	4
Forgetfulness, can't remember things	0	1	2	3	4
Difficulty making decisions	0	1	2	3	4
Slowed thinking, difficulty getting organized, can't finish things	0	1	2	3	4
Fatigue, loss of energy, getting tired easily	0	1	2	3	4
Difficulty falling or staying asleep	0	1	2	3	4
Feeling anxious or tense	0	1	2	3	4
Feeling depressed or sad	0	1	2	3	4
Irritability, easily annoyed	0	1	2	3	4
Poor frustration tolerance, feeling easily overwhelmed by things	0	1	2	3	4

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Stage 4: Moderate Activity

If your symptoms get worse or you have new symptoms, stop the activity immediately and tell your provider.



If your resting heart rate is over 100, do not exercise.

Write in your:

- Resting HR _____
- Active HR _____

Age	Heart Rate Range	
	70%	85%
15	144	174
20	140	170
25	136	165
30	133	161
35	129	159
40	126	153
45	122	148
50	119	144
55	115	140
60	112	136
65	108	132

220-Age=100% HR

Physical Activities

- limit to no more than 90 minutes with rest breaks as indicated on chart below
- wear personal protective equipment
- play non-contact sports
- take brisk hike (up to 3 mph with no additional load)
- perform resistance training (as directed by provider)
- do moderate military job tasks (climb, crawl with no additional load and jog to run as tolerated)
- increase repetitions of sit-ups, pull-ups, push-ups (no more than 50% of the number of reps you did on your last fitness test)

Activity	Rest
30 min.	2 hrs.
60 min.	4 hrs.
90 min.	6 hrs.

Thinking/Decision-making Activities

- limit to 40 minutes with rest breaks as indicated on chart below
- shop for groceries
- perform target practice
- practice driving in a simulator
- read a map while walking/land navigation
- manage your appointments and medications
- play video sports games or strategy games, such as chess and poker

Activity	Rest
20 min.	40 min.
30 min.	1 hr.
40 min.	1 hr. 20 min.

Body Movement/Balance Activities

- carry objects across rough terrain
- take part in agility drills with cutting and quick direction changes
- play foosball, ping-pong
- putt a golf ball
- jump rope
- swim with flip turns
- go kayaking

AVOID

- caffeine
- tobacco products

DO NOT!!!

- drink alcohol
- drive
- participate in combatives or collision sports



Practice good sleep habits (get 6-8 hours). See Healthy Sleep fact sheet at dvbic.dcoe.mil.

Please complete the Symptom Report on the back of this form before you see your provider.

PATIENTS

Patient Name: _____

ID#: _____

Date of Evaluation: _____

Date of Injury: _____

Symptom Report

Please rate the following symptoms **before** you see your health care provider. Please **DO NOT** attempt to score.

- 0 None** - Rarely if ever present; not a problem at all.
- 1 Mild** - Occasionally present, but it does not disrupt my activities. I can usually continue what I'm doing; doesn't really concern me.
- 2 Moderate** - Often present, occasionally disrupts my activities. I can usually continue what I'm doing with some effort. I feel somewhat concerned.
- 3 Severe** - Frequently present and disrupts activities. I can only do things that are fairly simple or take little effort. I feel I need help.
- 4 Very Severe** - Almost always present and I have been unable to perform at work, school or home due to this problem. I probably cannot function without help.

Handouts provided: _____

Symptoms

Feeling dizzy	0	1	2	3	4
Loss of balance	0	1	2	3	4
Poor coordination, clumsy	0	1	2	3	4
Headaches	0	1	2	3	4
Nausea	0	1	2	3	4
Vision problems, blurring, trouble seeing	0	1	2	3	4
Sensitivity to light	0	1	2	3	4
Hearing difficulty	0	1	2	3	4
Sensitivity to noise	0	1	2	3	4
Numbness or tingling on parts of my body	0	1	2	3	4
Change in taste and/or smell	0	1	2	3	4
Loss of appetite or increased appetite	0	1	2	3	4
Poor concentration, can't pay attention, easily distracted	0	1	2	3	4
Forgetfulness, can't remember things	0	1	2	3	4
Difficulty making decisions	0	1	2	3	4
Slowed thinking, difficulty getting organized, can't finish things	0	1	2	3	4
Fatigue, loss of energy, getting tired easily	0	1	2	3	4
Difficulty falling or staying asleep	0	1	2	3	4
Feeling anxious or tense	0	1	2	3	4
Feeling depressed or sad	0	1	2	3	4
Irritability, easily annoyed	0	1	2	3	4
Poor frustration tolerance, feeling easily overwhelmed by things	0	1	2	3	4

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Patient Activity Guidance After Concussion

Stage 5: Intensive Activity

If your symptoms get worse or you have new symptoms, stop the activity immediately and tell your provider.



If your resting heart rate is over 100, do not exercise.

Write in your:

- Resting HR _____
- Active HR _____

Age	Heart Rate Range	
	85%	100%
15	174	205
20	170	200
25	165	195
30	161	190
35	159	185
40	153	180
45	148	175
50	144	170
55	140	165
60	136	160
65	132	155

220-Age=100% HR

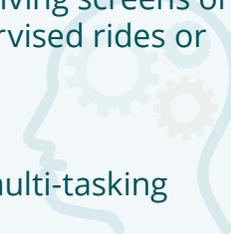
Physical Activities

- resume normal exercise routine (except combatives or contact/collision sports)
- participate in usual training activities or daily tasks
- duty-specific tasks, such as digging, loading/unloading equipment or changing a tire
- increase resistance training to your maximum



Thinking/Decision-making Activities

- limit to no more than 50 minutes at a time
- participate in usual military and social activities
- drive, as appropriate after pre-driving screens or assessments (could include supervised rides or driving simulator practice)
- use radio communication
- teach someone to do a task
- engage in problem-solving and multi-tasking
- do simulated weapons training
- communicate by signals during patrol duty



Body Movement/Balance Activities

- quickly navigate or run on uneven terrain with full load
- do a jump landing
- use night vision goggles or be exposed to bright lights, low light or fog
- go on patrol duty
- take part in simulations and virtual reality programs
- scan with rapid head/eye movements
- change position rapidly



AVOID

- caffeine
- tobacco products

DO NOT!!!

- drink alcohol
- participate in combatives or collision sports
- go outside the wire in a combat zone



Practice good sleep habits (get 6-8 hours). See Healthy Sleep fact sheet at dvbic.dcoe.mil.

Please complete the Symptom Report on the back of this form before you see your provider.

PATIENTS

Patient Name: _____

ID#: _____

Date of Evaluation: _____

Date of Injury: _____

Symptom Report

Please rate the following symptoms **before** you see your health care provider. Please **DO NOT** attempt to score.

- 0 None** - Rarely if ever present; not a problem at all.
- 1 Mild** - Occasionally present, but it does not disrupt my activities. I can usually continue what I'm doing; doesn't really concern me.
- 2 Moderate** - Often present, occasionally disrupts my activities. I can usually continue what I'm doing with some effort. I feel somewhat concerned.
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- 4 Very Severe** - Almost always present and I have been unable to perform at work, school or home due to this problem. I probably cannot function without help.

Handouts provided: _____

Symptoms					
Feeling dizzy	0	1	2	3	4
Loss of balance	0	1	2	3	4
Poor coordination, clumsy	0	1	2	3	4
Headaches	0	1	2	3	4
Nausea	0	1	2	3	4
Vision problems, blurring, trouble seeing	0	1	2	3	4
Sensitivity to light	0	1	2	3	4
Hearing difficulty	0	1	2	3	4
Sensitivity to noise	0	1	2	3	4
Numbness or tingling on parts of my body	0	1	2	3	4
Change in taste and/or smell	0	1	2	3	4
Loss of appetite or increased appetite	0	1	2	3	4
Poor concentration, can't pay attention, easily distracted	0	1	2	3	4
Forgetfulness, can't remember things	0	1	2	3	4
Difficulty making decisions	0	1	2	3	4
Slowed thinking, difficulty getting organized, can't finish things	0	1	2	3	4
Fatigue, loss of energy, getting tired easily	0	1	2	3	4
Difficulty falling or staying asleep	0	1	2	3	4
Feeling anxious or tense	0	1	2	3	4
Feeling depressed or sad	0	1	2	3	4
Irritability, easily annoyed	0	1	2	3	4
Poor frustration tolerance, feeling easily overwhelmed by things	0	1	2	3	4

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