Post-Concussion Syndrome Assessment

When symptoms persist for months, or in some cases years, after a mild traumatic brain injury, a thorough clinical assessment is the first step. At BNC, this typically combines a detailed clinical history and interview, neuropsychological testing, and – where appropriate and with informed consent – QEEG as an adjunct measure. For a general overview of how concussion is diagnosed, see the Mayo Clinic's overview of concussion diagnosis and treatment.

No DSM-5-TR Criteria for PCS

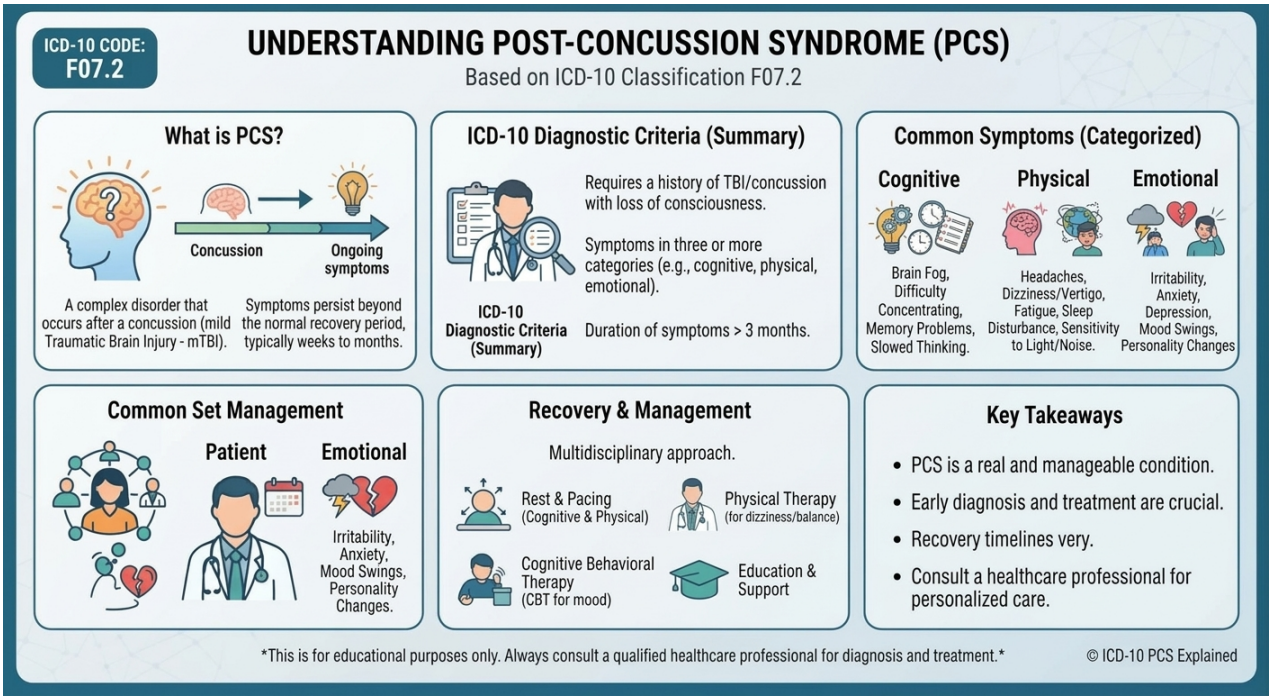
The DSM-5 (2013) and DSM-5-TR (2022) do not include post-concussion syndrome as a distinct diagnosis. Instead, persistent post-concussion symptoms are generally classified under Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury. The DSM-5 eliminated the term "postconcussional disorder," previously found in earlier versions, and now instructs clinicians to diagnose ongoing cognitive symptoms after TBI as "major or mild neurocognitive disorder due to traumatic brain injury" (Frontiers in Neurology; American Journal of Psychiatry; Theravive).

- The DSM-5-TR (2022) continues this classification, and there is no reintroduction of PCS as a separate diagnosis. Instead, it follows the same framework as DSM-5, requiring documentation of cognitive and sometimes behavioral symptoms persisting after TBI, but not labeling them as PCS (Expert Review of Neurotherapeutics).
- Multiple peer-reviewed articles also confirm that, in practice, persistent post-concussion symptoms are either categorized under neurocognitive disorders

due to TBI or, depending on the clinical picture, as somatic symptom disorder or other psychiatric diagnoses (L'Encéphale - Elsevier; Psychiatric Annals).

ICD-10 Criteria

The International Classification of Diseases, 10th Revision (ICD-10), by contrast, does recognise Postconcussional Syndrome as a diagnosis (codes F07.81/F07.2) for symptoms that persist beyond the expected recovery window – typically three weeks to three months following head trauma.



To meet the ICD-10 criteria, a person requires a history of head trauma and at least three of the following symptoms:

- **Physical complaints:** headache, dizziness, malaise, fatigue, or noise intolerance
- **Emotional changes:** irritability, emotional lability, depression, or anxiety
- **Cognitive complaints:** difficulty with concentration or memory
- **Insomnia** and sleep disturbances
- Reduced tolerance to alcohol or stress

PCS symptoms vary widely between individuals and frequently overlap with other neuropsychiatric conditions. Conventional diagnostic tools remain essential, but on

their own do not always capture the full extent of the underlying neural dysfunction – which is why additional testing can add value in more complex or persistent cases.

Neuropsychological Assessment

A neuropsychological battery uses a combination of paper-and-pencil and computerised tests to evaluate attention, memory, language, problem-solving, processing speed and executive functioning. This gives an objective picture of cognitive strengths and weaknesses that can be compared against expected norms for age and background.

Test of Variables of Attention (T.O.V.A.)

The T.O.V.A. is a computer-based continuous performance task that measures attention, impulse control, processing speed and distractibility. It is often used alongside broader neuropsychological testing to build a fuller picture of attentional function after injury.

QEEG as an Adjunct Assessment Tool

In some cases, we may also use QEEG (quantitative electroencephalography, or “brain mapping”) as an additional, adjunct measure alongside clinical assessment and neuropsychological testing. QEEG is not a stand-alone diagnostic tool, and is always used together with, not instead of, the clinical picture. Read our full explanation of what QEEG is, how it’s used at BNC, its usefulness and its limitations.

Once assessment is complete, treatment is planned around your specific symptoms — read more on our Post-Concussion Syndrome Treatment page.

Frequently Asked Questions

How is post-concussion syndrome diagnosed?+

PCS is typically assessed based on your reported symptoms and history of head injury, combined with a clinical interview, neurological and neuropsychological testing. There is no single definitive test – diagnosis relies on a comprehensive clinical evaluation, and in Australia the ICD-10 criteria are commonly used as a diagnostic reference point.

Is there a blood test or scan that can diagnose PCS?+

No single scan or blood test can diagnose PCS. Standard CT and MRI scans are usually normal. Assessment instead relies on clinical evaluation and neuropsychological testing, with tools like QEEG sometimes used as an additional adjunct measure.

What does a neuropsychological assessment for PCS involve?+

It typically combines paper-and-pencil and computerised tests, such as the T.O.V.A., assessing attention, memory, language, problem-solving, processing speed and executive functioning, compared against expected norms for your age and background.

Is QEEG used to diagnose PCS?+

No. QEEG is not a stand-alone diagnostic tool for PCS. It is used as an adjunct alongside clinical assessment and neuropsychological testing, not as a replacement for them. See our dedicated QEEG page for a full explanation of how this works at BNC.

How long does an assessment take?+

This varies depending on which combination of clinical interview, neuropsychological testing and any adjunct QEEG assessment is recommended for your situation. Your psychologist will discuss the expected process and

timeframe with you at your initial consultation.

Can a concussion trigger or worsen ADHD symptoms?+

Yes. A concussion can affect attention, concentration and emotional regulation, and if you have had more than one concussion the effects can be cumulative. If you already have ADHD, your symptoms may feel worse for a time after an injury. An assessment can help separate the effects of the concussion from pre-existing ADHD; see our adult ADHD assessment page if ADHD has not been assessed before.

(03) 9848 9100

Updated on: 23/08/2026 by: Dr Jacques Duff – PhD; BA Psych; Grad Dip Applied Psychology; FANSA, Clinical Neuroscientist.
Reviewed on: 23/08/2026 by: Bernard Ferriere – Clinical Psychologist; BA; Grad Dip Applied Psychology; Dip Clinical Hypnosis; MAPS