

MEDISYS

REHABILITATION, INC.

ADULT QUESTIONNAIRE

Anything that requires a date, please click in the space provided for a pull down calendar

This form has been completed by (CHECK ONE): Patient Other **Date:** _____

(Note: If not completed by the patient, please provide the following information):

Completed by: _____ **Relationship to Patient:** _____

Home Phone: () _____ **Work:** () _____ **Cell:** () _____

Patient's full name: _____ **DOB; age:** _____ ;

Sex: M F **Hand used for writing:** Right Left **Years of education:** _____

Ethnic/racial background: _____ **Citizenship:** _____

Religion: _____ **Primary Language:** _____ **Secondary Language:** _____

Address (Street, City, State, Zip Code): _____

Closest Metro Area/Distance: _____ **Rural/Urban/Suburban:** _____

Who referred you for this evaluation? _____

What is your understanding of the reasoning for the referral? _____

Current problem areas/areas of disability: _____

I. DAILY ACTIVITIES:

Please describe an average or typical day for you, including when you awaken, what you do during the day, when you sleep and eat, etc.:

What limitations, if any, do you have with regard to activities of daily living (e.g., dressing, grooming, hygiene, toileting)?

What limitations, if any, do you have with regard to household chores (e.g., laundry, yard work, cooking, home repairs, cleaning)?

Do you drive a car? [] Yes [] No

Can you manage your money and balance a checkbook? [] Yes [] No

II. EARLY HISTORY:

You were born (check one): [] On time [] Prematurely [] Late

Your weight at birth: ____ pounds ____ ounces

Were there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need for oxygen, special equipment, convulsions, illnesses, etc.)? [] Yes [] No

If yes, please describe: _____

Check any and all that applied to your mother while she was pregnant with you:

- Accident: _____
- Alcohol Use
- Cigarette Smoking
- Illness (toxemia, diabetes, high blood pressure, infection, RH incompatibility, etc.)
- Medication use (prescribed or over the counter): _____
- Psychological Problems
- Drug Use (marijuana, speed, cocaine, LSD, etc.)
- Poor Nutrition

During her pregnancy, did your mother live near a polluted area (e.g., toxic waste dump) or other hazardous area (nuclear plant, industrial area, pesticide sprayed area, etc.)? Yes No

If yes, please describe: _____

Please indicate your developmental progress as it has been reported to you:

	<u>Early</u>	<u>Average</u>	<u>Late</u>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

As a child, did you have any of these conditions? (Check all that apply)

- Attention Problems
- Muscle Tightness or Weakness
- Hearing Problems
- Frequent Ear Infections
- Other Problems: _____
- Head Injury
- Clumsiness
- Speech Problems
- Learning Disability

Were you ever tested for developmental disabilities (e.g., cerebral palsy, specific learning disabilities, autism, etc.)? Yes No

If yes, please describe: _____

III. MEDICAL HISTORY:

Check any and all conditions that have been diagnosed during your life time. Please add any helpful details as well if the condition was serious (e.g., age at diagnosis, treatment provided):

- Allergies
- Asthma
- Brain Infection or Disease
- Cancer/ Chemotherapy
- Cerebral Palsy
- Chicken Pox
- Colds (excessive)
- Lung (Respiratory) Disease
- Measles
- Meningitis
- Oxygen Deprivation
- Pneumonia
- Poisoning
- Polio

- | | |
|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Fevers (104 F or higher) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Disease/ Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Kidney Problems/ Disease | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> AIDS, ARC, or HIV + | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Artery Disease | <input type="checkbox"/> Malnutrition |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Hazardous Substance Exposure | <input type="checkbox"/> Pulmonary Problems |
| <input type="checkbox"/> Huntington's Disease | <input type="checkbox"/> Radiation Exposure/Therapy |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Senility (Dementia) |
| <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Other Disease/ Disability: _____ | |

Details: _____

As a child, were you ever exposed to excessive amounts of lead (e.g., eating paint chips, living next to high concentrations of automobile exhaust fumes)? Yes No

If yes, please explain: _____

Surgical history: _____

Illnesses requiring hospitalization? (Please specify illness & total frequency of hospitalizations):

Illness requiring medical intervention but *not* hospitalization? (Please indicate total frequency of occurrences and type of intervention if applicable): _____

Have you ever suffered a serious injury to your head? Yes No
 If yes, please describe: _____

Indicate your nutrition as a child/adolescent: Excellent Average Poor

Indicate any medications that were regularly given to you as a child: _____

Please check off the diagnostic tests that you have recently had:

- | | |
|--|---|
| <input type="checkbox"/> X rays | <input type="checkbox"/> Lumbar puncture/spinal tap |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> ECG |
| <input type="checkbox"/> Bone Density | <input type="checkbox"/> EEG |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Swallow studies |
| <input type="checkbox"/> Neurological exam | <input type="checkbox"/> Multi-chemical profile |
| <input type="checkbox"/> Urinalysis | <input type="checkbox"/> PET scan |
| <input type="checkbox"/> MRI/CT scan | <input type="checkbox"/> Urodynamic |
| <input type="checkbox"/> Cultures | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> GI Review | |

For any indicated above, please describe in detail (i.e., type of test, date of test, findings of test):

Name of the physician most familiar with your recent issues? _____

Address: _____

Phone: _____

Date of last medical checkup and findings: _____ ;

Date of next scheduled appointment: _____

How often are you seen for follow up? _____

Do you have any upcoming surgeries planned? Yes No

If **yes**, please describe: _____

Do you have epilepsy or a seizure disorder? Yes No

If **yes**, please check the one you have been diagnosed with and describe the symptoms:

Partial

Generalized

- Simple partial (Jacksonian)
- Complex partial (Psychomotor)
- Partial evolving into generalized
- Unclassified Type

- Absence (Petit mal)
- Tonic-clonic (Grand mal)

Describe symptoms: _____

Please note all medications you take at present, including their dosage and frequency given (e.g., Depakote, 100 mg., 2 tablets in the a.m., 1 tablet in the afternoon, and 4 tablets in the evening):

<u>Name</u>	<u>Dosage/ Amount</u>	<u>Frequency Given</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. FAMILY HISTORY

What is your **biological** mother's name (include maiden name)? _____

Is she alive? [] Yes [] No

If **no**, what was the cause of death, her age of death, and your age at the time of her death? Cause: _____; her age: _____; my age: _____

Mother's level of education: _____

Mother's current (or past, if retired or deceased) occupation: _____

Does/did your mother have a known or suspected learning disability? [] Yes [] No

If **yes**, please describe: _____

What is your **biological** father's name? _____

Is he alive? [] Yes [] No

If **no**, what was the cause of his death, his age of death, and your age at the time of his death? Cause: _____; his age: _____; my age: _____

Father's level of education: _____

Father's current (or past, if retired or deceased) occupation: _____

Does/did your father have a known or suspected learning disability? [] Yes [] No

If yes, please describe: _____

When you were born, what was your mother's age? _____ Father's age? _____

Do you have siblings? [] Yes [] No

If yes, please list their names and ages: _____

If yes, were there any unusual problems – physical, academic, psychological – associated with any of your siblings? [] Yes [] No

If yes, please describe: _____

Who raised you?

- [] Biological Parent(s) [] Relatives
- [] Biological Parent Plus Other Person [] Foster Parents
- [] Adoptive Parents [] Institutional Setting
- [] Other (please indicate who): _____

What language(s) was/were spoken in the home when you were a child?

Primary: _____ Secondary: _____

Please check all that existed in **close biological family** members (parents, brothers, sisters, grandparents, aunts, uncles), note who it was, and describe the problem indicated:

<u>Physical Problems:</u>	<u>Who:</u>	<u>Describe:</u>
[] Epilepsy or Seizures	_____	_____
[] Learning Disability	_____	_____
[] Mental Retardation	_____	_____
[] Heart Problems	_____	_____
[] Hypertension	_____	_____
[] Cancer	_____	_____
[] Other: _____	_____	_____

<u>Neurologic (Brain) Disease:</u>	<u>Who:</u>	<u>Describe:</u>
<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Alzheimer's Disease/ Senility	_____	_____
<input type="checkbox"/> Huntington's Disease	_____	_____
<input type="checkbox"/> Multiple Sclerosis	_____	_____
<input type="checkbox"/> Parkinson's Disease	_____	_____
<input type="checkbox"/> Brain Tumor	_____	_____
<input type="checkbox"/> Muscular Dystrophy	_____	_____
<input type="checkbox"/> Other: _____	_____	_____

<u>Psychiatric Illness:</u>	<u>Who:</u>	<u>Describe:</u>
<input type="checkbox"/> Alcoholism/Drug Dependency	_____	_____
<input type="checkbox"/> Bipolar (Manic Depression)	_____	_____
<input type="checkbox"/> Depression	_____	_____
<input type="checkbox"/> Anxiety	_____	_____
<input type="checkbox"/> Personality Disorder	_____	_____
<input type="checkbox"/> Schizophrenia	_____	_____
<input type="checkbox"/> Other Psychiatric Illness	_____	_____
<input type="checkbox"/> Speech or Language Disorder	_____	_____
<input type="checkbox"/> Other Disease/ Disorder	_____	_____

Is anyone in your family left-handed? Yes No

If yes, please indicate who: _____

V. PSYCHOSOCIAL HISTORY:

Current marital status: Married Single Divorced Separated Widow

If **married**, name of current spouse: _____

Spouse's occupation: _____

Spouse's health: [] Excellent [] Good [] Poor

Number of years married: _____

Not married, but living with someone? [] Yes [] No

If **yes**, his/her age: _____

His/her health: [] Excellent [] Good [] Poor

His/her occupation: _____

Do you have children? [] Yes [] No

If **yes**, please list child(ren's) name(s), age(s), and sex: _____

With whom are you currently living? _____

Do you live in a: [] House [] Apartment [] Hotel [] Other: _____

Describe the home/apartment/other: _____

Describe architectural barriers, if any: _____

How far from previous job (if applicable)? _____

Describe any organizations, volunteering, hobbies, reading interests, or other leisure-time activities in which you engaged in prior to the accident/injury: _____

Describe any organizations, volunteering, hobbies, reading interests, or other leisure-time activities in which you currently engage: _____

Please indicate your current financial status:

Income:

Expenses:

Salary \$ _____ /mo.

Rent/ Mortgage \$ _____ /mo.

Family \$ _____ /mo.

Food \$ _____ /mo.

W.C.	\$ _____ /mo.	Automobile	\$ _____ /mo.
V.A.	\$ _____ /mo.	Utilities	\$ _____ /mo.
S.S.	\$ _____ /mo.	Medical	\$ _____ /mo.
Pension	\$ _____ /mo.	Insurance	\$ _____ /mo.
Other	\$ _____ /mo.	Personal/Misc.	\$ _____ /mo.
		*Services	\$ _____ /mo.
Total Income	\$ _____ /mo.	Total Expenses	\$ _____ /mo.

*If applicable, services can include those that assist with ADL's you are no longer capable of performing, such as lawn services, transportation services, pet services, grocery services, etc. If you receive such services, please indicate these: _____

Are you making ends meet? [] Yes [] No

Do you receive (or have you ever received) any state-funded services (e.g., state vocational rehabilitation or employment services), or have you received charitable funds? [] Yes [] No

If **yes**, please describe: _____

Have you ever been under care of a psychiatrist, psychologist, or counselor? [] Yes [] No

If **yes**, by whom and for what reason(s)? _____

If **yes**, is the therapy current? [] Yes [] No (dates of service: _____ to _____)

Do you feel treatment was/is helpful? [] Yes [] No

If **no**, why not? _____

Have you ever thought of suicide? [] Yes [] No

If **yes**, when was the last time you thought about it? _____

Have you ever had a prior psychological or neuropsychological evaluation? [] Yes [] No

If **yes**, please indicate the name of the psychologist: _____

Address of psychologist: _____

Phone number of psychologist: _____

VI. LEGAL HISTORY:

Have you ever been arrested? [] Yes [] No

(If **yes**, please explain): _____

Have you ever been convicted of a crime, or pled guilty to a crime? [] Yes [] No

(If **yes**, please explain): _____

Have you ever been incarcerated or on probation? [] Yes [] No

(If **yes**, please explain): _____

Have you ever had a lawsuit filed against you? [] Yes [] No

(If **yes**, please explain): _____

Have you ever filed a lawsuit against someone else? [] Yes [] No

(If **yes**, please explain): _____

VII. EDUCATIONAL HISTORY:

Number of years of formal education completed: _____

Did you receive a: [] Diploma [] G.E.D. [] Neither

Where did you attend school (e.g., USA, Mexico, etc.)? _____

How would you describe your performance as a student? [] A/B [] B/C [] C/D [] D/F

What was your best subject(s)/grade(s)? _____

What was your weakest subject(s)/grade(s)? _____

Were you ever held back to repeat a grade? [] Yes (Grade: _____) [] No

Were you ever in any special class(es) or received special education services? [] Yes [] No

If **yes**, at what age/grade and what type of class? _____

Did you attend college? [] Yes [] No

If **yes**, what college? _____

Major? _____

Degree (e.g., M.A., B.A., Ph.D., J.D., M.D.)? _____

VIII. OCCUPATIONAL HISTORY:

Are you currently employed? [] Yes [] No

If **no**, are you on medical leave? [] Yes [] No

Were you employed at the time of the event in question? [] Yes [] No

If **yes**, where were you employed and what was your position? _____

If **yes**, was this a part-time or full-time position? _____

What is your current (or most recent, if not working) job title? _____

Salary: [] Under \$10,000 [] \$10,000 - \$29,999 [] \$30,000 - \$50,000 [] Over \$50,000

How long have you (or had you) been on this job? _____

Please give a brief description of your responsibilities: _____

For all jobs held in the last 5 years, please complete the following:

<u>Company</u>	<u>Job Title</u>	<u>Salary</u>	<u>Years Employed</u>	<u>Dates of Service</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you been in the military? [] Yes [] No

If **yes**, please give branch, dates of service, reason for discharge, any disability rating, rank/duties, and type of training: _____

At any time on a job, were you exposed to toxic, hazardous, noxious, or otherwise dangerous substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc.)? [] Yes [] No

If **yes**, please explain: _____

What was your highest level of occupational achievement? _____

What was your favorite job? _____

What would be your ideal job for the future? _____

Have you ever filed a worker's compensation claim? [] Yes [] No

If **yes**, please explain: _____

Do you have skills/experience in the following areas?

- | | |
|---|---|
| <input type="checkbox"/> Office Machines | <input type="checkbox"/> Farm Equipment |
| <input type="checkbox"/> Construction Equipment | <input type="checkbox"/> Hand Tools |
| <input type="checkbox"/> Transport Equipment | <input type="checkbox"/> Machine/Shop Tools |
| <input type="checkbox"/> Bookkeeping | <input type="checkbox"/> Inventory Control |
| <input type="checkbox"/> Shipping/Receiving | <input type="checkbox"/> Scheduling |
| <input type="checkbox"/> Supervising | <input type="checkbox"/> Instructing |

Do you have any special licenses or certificates? [] Yes [] No

If **yes**, please specify: _____

Do you have working knowledge of special tools/equipment? [] Yes [] No

If **yes**, please specify: _____

IX. SUBSTANCE USE HISTORY:

Alcohol:

I drink alcohol: [] rarely or never [] 1 - 2 days per week [] 3 - 5 days per week [] daily

If you indicated **rarely or never**, did you used to drink alcohol? [] Yes [] No

If **yes** to above, at what ages did you start (age: _____) and stop (age: _____) drinking?

If you indicated you consume alcohol currently, at what age did you start? Age: _____

Preferred type(s) of drinks: _____

Usual number of drinks had at a time: _____

My last drink was: [] less than 24 hours ago [] 24 to 48 hours ago [] over 48 hours ago

Is there a family history of alcohol abuse? [] Yes [] No

If **yes**, please list the relationship: _____

Check all that apply:

- I can drink more than most people my age and size before I get drunk.
- I sometimes get into trouble (e.g., fights, legal trouble, work trouble, conflicts with family, accidents) after drinking.
- I sometimes black out after drinking.
- I have gone through alcohol withdrawal.

Drugs:

Please indicate all the drugs you are now using or have used in the past:

	<u>Presently Using</u>	<u>Used in the Past</u>	<u>Date last used</u>
Amphetamines (including diet pills)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Barbiturates (downers)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cocaine or crack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hallucinogens (LSD, PCP, ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inhalants (glue, spray cans, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	_____
Opiate narcotics	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco/nicotine products	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other drugs: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

For any drugs you indicated usage of above (past or present), please specify which, as well as frequency of usage (e.g., if you use tobacco/nicotine products, is this in the form of cigarettes, e-cigarettes, vaping, or smokeless tobacco? How many times per day do you or did you use? At what age did you start, and stop if applicable?): _____

Are you dependent on any of the above drugs, or on any prescription drugs? Yes No

If **yes**, which one(s)? _____

Is there a family history of drug abuse? Yes No

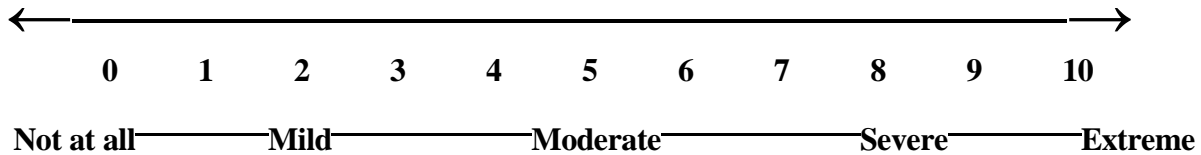
If **yes**, please list relationship(s): _____

Check all that apply:

- I have gone through drug withdrawal.
- I have used I.V. drugs.
- I have been in drug treatment.

X. SYMPTOM SURVEY:

Below is a list of symptoms that you may or may not be experiencing. If you experience the symptom, rate the severity on a scale of 1 to 10 (**1 = minimal, 10 = extreme**), and indicate if it is a symptom you are experiencing **now** (related to injury, or within the last 12 months) or an old symptom (**prior to injury**) by placing the rating (1 - 10) in the appropriate place (**now or prior to injury**). You can have symptoms that have changed over time and/or existed before your injury. If so, indicate the severity in both places. This will help us in understanding how your symptoms have changed over time. Remember, only rate symptoms that apply to you. **If the symptom does not apply to you, do nothing.**



Problem Solving: (Select number from Dropdown, based on number scale above)

Now	Prior to	
_____	_____	Difficulty figuring out how to do new things
_____	_____	Difficulty planning ahead
_____	_____	Difficulty figuring out problems that most other people can do
_____	_____	Difficulty thinking as quickly as needed
_____	_____	Difficulty doing things in the right order (sequence problems)
_____	_____	Difficulty verbally describing the steps involved in doing something
_____	_____	Difficulty changing a plan/activity in a reasonable amount of time
_____	_____	Difficulty doing more than one thing at a time (multi-tasking)
_____	_____	Difficulty switching from one activity to another

Speech, Language, and Academic Skills: (Select from the Dropdown, based on the number scale above)

Now	Prior to	
_____	_____	Difficulty finding the right word to say
_____	_____	Difficulty understanding what others are saying
_____	_____	Difficulty writing letters or words (not due to motor problems)
_____	_____	Slurred speech

_____	_____	Difficulty with math (e.g., checkbook balancing, making change, etc.)
_____	_____	Difficulty understanding what I read
_____	_____	Difficulty spelling

Concentration and Awareness: (Select number from Dropdown, based on number scale from page 16)

Now	Prior to	
_____	_____	Highly distracted
_____	_____	Losing my train of thought easily
_____	_____	Problems concentrating
_____	_____	Become easily confused or disoriented
_____	_____	My mind goes blank

Memory: (Select number from Dropdown, based on number scale from page 16)

Now	Prior to	
_____	_____	Forgetting where I leave things (e.g., keys, gloves, etc.)
_____	_____	Forgetting names
_____	_____	Forgetting what I should be doing
_____	_____	Problems finding my way around places I have been to before
_____	_____	Forgetting where I am or where I am going
_____	_____	Not aware of time (i.e., time of day, season, year)
_____	_____	Forgetting events that happened quite recently (e.g., my last meal)
_____	_____	Forgetting events that happened long ago (months or years)
_____	_____	Needing someone to give me a hint so I can remember things
_____	_____	Relying more and more on notes to remember things
_____	_____	Forgetting the order of things (e.g., when cooking, etc.)
_____	_____	Forgetting factual information (e.g., the president)
_____	_____	Forgetting faces of people that I know (when they are not present)
_____	_____	Frequently forgetting appointments/meetings

Motor and Coordination: (Select number from Dropdown, based on number scale from page 16)

Now	Prior to			
_____	_____	Difficulty doing things I should automatically be able to do (e.g., brushing teeth, combing hair, etc.)		
_____	_____	Problems drawing or copying		
_____	_____	Difficulty dressing		
_____	_____	My handwriting has changed		
_____	_____	Slowed reaction time		
_____	_____	Walking more slowly than other people		
_____	_____	Balance problems		
_____	_____	Often bumping into things		
			<u>Right</u>	<u>Left</u>
			<u>Both</u>	
_____	_____	Fine motor control problems (e.g., using a pencil, key, etc.)	[]	[]
_____	_____	Weakness/paralysis on one side of my body	[]	[]
_____	_____	Tremor or shakiness	[]	[]
_____	_____	Muscle spasms, twitching	[]	[]
_____	_____	Feeling stiff	[]	[]
_____	_____	My muscles tire quickly	[]	[]

Sensory:

Now	Prior to	
_____	_____	Loss of sense of taste, bad taste
_____	_____	Loss of sense of smell
_____	_____	Difficulty telling right from left
_____	_____	Difficulty looking quickly from one object to another object
_____	_____	Difficulty recognizing objects or people
_____	_____	Need to squint or move closer to see clearly
_____	_____	Double vision
_____	_____	See unusual things (that others don't see)

_____	_____	Blurred vision			
_____	_____	Blank spots in vision			
_____	_____	See "stars" or flashes of light			
_____	_____	Loss of vision			
			<u>Right</u>	<u>Left</u>	<u>Both</u>
_____	_____	Loss of feeling or numbness	[]	[]	[]
_____	_____	Tingling or strange skin sensations	[]	[]	[]
_____	_____	Pins and needles	[]	[]	[]
_____	_____	Difficulty telling hot from cold	[]	[]	[]
_____	_____	Burning skin	[]	[]	[]
_____	_____	Problems seeing on one side	[]	[]	[]
_____	_____	Parts of my body seem as if they do not belong to me	[]	[]	[]
_____	_____	Hearing loss	[]	[]	[]
_____	_____	Hear unusual things (that others don't)	[]	[]	[]
_____	_____	Ringing in my ears	[]	[]	[]
_____	_____	Unaware of things on one side of my body	[]	[]	[]

Behavior: (Select number from Dropdown, based on number scale from page 16)

Now	Prior to	
_____	_____	Sadness or depression
_____	_____	Anxiety or nervousness
_____	_____	Irritability
_____	_____	Sleeping problem: [] falling asleep [] staying asleep
_____	_____	Become angry more easily
_____	_____	Euphoria (feeling on top of the world)
_____	_____	Much more emotional (e.g., cry more easily)
_____	_____	Loss of interest
_____	_____	Change in attitudes (more positive or negative)

- _____ Doing things automatically (on autopilot)
- _____ Less inhibited (do things I would not do before)
- _____ Difficulty being spontaneous (hard to stray from a routine)
- _____ Change in eating habits: [] Loss of appetite [] Overeating
- _____ Change in interest in sex: [] Loss of interest [] Increased

Physical:

Check which of these actions you have difficulty with, and if checked, please rate the extent from 1 – 10.

- | | |
|------------------------------|-------------------------------|
| [] Feeling (Extent: _____) | [] Grasping (Extent: _____) |
| [] Reaching (Extent: _____) | [] Talking (Extent: _____) |
| [] Seeing (Extent: _____) | [] Hearing (Extent: _____) |
| [] Standing (Extent: _____) | [] Sitting (Extent: _____) |
| [] Walking (Extent: _____) | [] Climbing (Extent: _____) |
| [] Bending (Extent: _____) | [] Balancing (Extent: _____) |
| [] Kneeling (Extent: _____) | [] Stooping (Extent: _____) |
| [] Lifting (Extent: _____) | [] Breathing (Extent: _____) |
| [] Driving (Extent: _____) | |

Do you have special problems with the following environments?

- | | |
|-----------------------------|---------------------------------|
| [] Inside (Extent: _____) | [] Dusty/dirty (Extent: _____) |
| [] Outside (Extent: _____) | [] Noisy (Extent: _____) |
| [] Heat (Extent: _____) | [] Heights (Extent: _____) |
| [] Cold (Extent: _____) | [] Vibrations (Extent: _____) |
| [] Humid (Extent: _____) | |

Do you have any problems with the following?

- | | |
|-------------------------------|---|
| [] Bowels (Extent: _____) | [] Nausea (Extent: _____) |
| [] Urination (Extent: _____) | [] Sexual Activity (Extent: _____) |
| [] Headaches (Extent: _____) | [] Abnormal menstruation (Extent: _____) |
| [] Dizziness (Extent: _____) | [] Excessive tiredness (Extent: _____) |

Please indicate any assistive aids you use (e.g., wheelchair, walker, cane, etc.):

Do you have any problems with your medical equipment? Yes No

If **yes**, please specify: _____

Do you wear glasses or contact lenses? Yes No

If **yes**, please specify which/what for: _____

Do you experience any pain with the following? Walking Standing Sitting Arising

Do you have any visible scars? Yes (location(s): _____) No

Height: _____ Weight, pre-injury: _____ Weight, present: _____

Overall, my symptoms have developed: Slowly Quickly

My symptoms occur: Occasionally Often

Over the past 6 months, my symptoms have: Improved Stayed the same Worsened