Case Report Forms

Outcomes TBI Patients
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<thead>
<tr>
<th>Procedure</th>
<th>Admission</th>
<th>Hospital</th>
<th>2W</th>
<th>3M⁺</th>
<th>6M</th>
<th>12M</th>
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* Outcomes administration at the 3M time conducted only by telephone
+ Collected only for those admitted to the Ward or ICU
⁶ Collected only for those admitted to the ICU
## Patient Management

### Patient Identification Information

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### FOLLOW UP APPOINTMENTS

**Milestone Windows:**
- **CA+MRI**, 2-wk MRI must be completed 14 ± 4 days from DOI. 2-week outcomes must be completed ± 3 days of the 2-wk MRI.
- **CA**, 2-week outcomes must be completed ± 4 days of 14 days from DOI.
- **Outcomes**, 3-mos must be completed ± 7 days of 90 days from DOI.
- **CA+MRI**, MRI at 6-mo must be completed ± 14 days of 180 days from DOI, with 6-mo outcomes ± 14 days of the 6-mo MRI.
- **CA and BA patients**, 6-mo outcomes must be completed ± 14 days of 180 days from DOI.
- **6 Mo BTACT**, should be completed within ± 7 days of Outcomes (but not on the same day and no greater than 201 days from injury).
- **Outcomes**, 12 mos must be completed ± 30 days of 360 days from DOI.

**Coding for “Did Pt Show Up”:** Enter N/A if pt has expired or withdrawn. The Appointment Outcome field can be left blank. For CA cohort, code the MRI Milestone fields as N/A.

### Original Cohort
- CA-MRI
- CA
- BA
- CA-MRI-HDFT
- CA-MRI Friend Control
- CA Friend Control
- CA Ortho Control
- CA-MRI Ortho Control

### Current Cohort at 2 Weeks
(Fill in when Appointment Result is known. Leave blank if withdrawn or died before window closed.)
- Cohort does not change after 2 Weeks.
- CA-MRI
- CA
- BA
- CA-MRI-HDFT
- CA-MRI Friend Control
- CA Friend Control
- CA Ortho Control
- CA-MRI Ortho Control

### Click for Calendar

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<th>Scheduled Date Time</th>
<th>Did the patient show up?</th>
<th>Appointment Outcome</th>
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<th>Transport Reimbursement ($)</th>
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**Biospecimen Notes**

**Imaging Notes**

**Follow Up Notes**

**Contact and Communications Log**

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Contact Info

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Alt Phone1

Alt Phone1 Type

- Cell
- Work

Alt Phone2

Alt Phone2 Type

- Cell
- Work

Text Message Address


## Patient Identification Information

### Site Name
- BCM-TIRR-UTHSCH
- DH-CH
- Emory
- HCMC
- IU Health Methodist Hospital
- MCW - Froedtert Hospital
- MGH-Spaulding
- UCSF
- Univ. of Cincinnati
- Univ. of Maryland
- Univ. of Miami
- Univ. of Pittsburgh
- Univ. of Washington
- U Penn
- Univ. of Utah
- UT Austin
- UT Southwestern
- VCU

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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SST</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>PAXgene</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
# MRI Scan Information Log 2Wk

## Patient Identification Information

### Site:
- BCM-TIRR-UTHSCH
- DH-CH
- Emory - Grady Memorial Hospital
- Hennepin County Medical Center
- Indiana University Health Methodist Hospital
- Medical College of Wisconsin - Froedtert Hospital
- MGH-SRH
- UCSF
- Univ. of Cincinnati
- Univ. of Maryland
- Univ. of Miami
- Univ. of Pittsburgh
- Univ. of Washington
- University of Utah Health Care
- UPenn
- UT Austin
- UT Southwestern
- VCU

### SC/RA Name: 

### SC/RA Phone: 

### Anticipated Date of MRI:

### MRI Operator Initials: 

### Date and Time of MRI:

### Time Since Injury:

### Date Time MRI sent to LONI:

### Did this scan use Siemens HDFT Protocol? 
- Yes
- No
- NA

## 1. Localizer

Check participant positioning in the head coil. Re-position and re-scout if necessary.

### Comments:

Localizer completed?
- Yes
- No

## 2. Sagittal 3D T1 MP-RAGE/IR-SPGR

Position the acquisition box to contain the whole brain and skull. Studies without full brain coverage cannot be processed. Do not oblique the scanning slices to compensate for subject held tilt. Scan as straight Sagittal.

### Comments:

Sagittal 3D T1 MP-RAGE/IR-SPGR Completed?
- Yes
- No

## 3. Sagittal 3D T2* GRE/SWAN/SWI
Reproduce the positioning used for the MP-RAGE/IR-SPGR sequence obtained in item 2.

Comments:

Sagittal 3D T2* GRE/SWAN/SWI Completed?
Circle Yes or No

4. Axial DTI
Orientation is Straight Axial. Prescribe the 3D Slab inferior to superior. Do not oblique the slab to compensate for subject head tilt. Scan as Straight Axial.

Comments:

Axial DTI Completed?
Circle Yes or No

5. Resting State fMRI
Orientation is Straight Axial. Do not oblique scans. Position on mid-sagittal slice from tri-planar scout. The acquisition stack should be placed just above the most superior point in the brain and should cover the cerebellum if possible.

Comments:

Resting State fMRI Completed?
Circle Yes or No

6. Sagittal 3D T2-FLAIR CUBE/SPACE/VISTA
Reproduce the positioning used for the MP-RAGE/IR-SPGR sequence obtained in item 2.

Comments:

Sagittal 3D T2 FLAIR CUBE/SPACE/VISTA Completed?
Circle Yes or No

7. Sagittal 3D T2-TSE
Reproduce the positioning used for the MP-RAGE/IR-SPGR sequence obtained in item 2.

Comments:

Sagittal 3D T2-TSE Completed?
Circle Yes or No

Radiologist Report (for use by UCSF Central Readers)

Radiologist Name:

Report Date and Time:

Findings:
Positive current MRI for TBI
Negative current MRI for TBI

Are there any incidental findings that warrant reporting to the site investigator?
Yes
No

PI Contacted Date

Patient Contacted Date

Explain why yes:

Other Findings, MRI technical issues:

Traumatic Intracranial Findings
## Schedule for Follow-up Assessment Windows

### 2 Week Follow-up Assessment Windows

<table>
<thead>
<tr>
<th>Cohort</th>
<th>MRI: 14 days post-injury ± 4 days</th>
<th>Outcomes: ± 3 days of 2-week MRI</th>
<th>Outcomes: 14 days post-injury ± 4 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA + MRI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CA/BA Cohorts</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3 Month Telephone Follow-up Assessment Window

<table>
<thead>
<tr>
<th>All Cohorts</th>
<th>Outcomes: 90 days post-injury ± 7 days</th>
</tr>
</thead>
</table>

### 6 Month Follow-up Assessment Windows

<table>
<thead>
<tr>
<th>Cohort</th>
<th>MRI: 180 days post-injury ± 14 days</th>
<th>Outcomes: ± 14 days of 6-month MRI</th>
<th>BTACT: ± 7 days of Outcomes (but not on the same day)</th>
<th>Outcomes: 180 days post-injury ± 14 days</th>
<th>BTACT: ± 7 days of Outcomes (but not on the same day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA + MRI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CA/BA Cohorts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 12 Month Follow-up Assessment Window

<table>
<thead>
<tr>
<th>All Cohorts</th>
<th>Outcomes: 360 days post-injury ± 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Outcome Measure</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Screening Protocol (5-9 minutes) | • Assessment of speech intelligibility  
• Galveston Orientation and Amnesia Test (Standard, Written, and Modified GOAT)  
• Post-traumatic amnesia (PTA) assessment | 2m 5m 2m | 2W, then as needed | N/A |
| Abbreviated Battery (AAB) (60-85 minutes- includes screening) | • Sections:  
  • Demographic Variables  
  • Vocational History  
  • Pre-morbid medical history  
  • Prior TBI screen  
  • Alcohol Use Disorders Identification Test (AUDIT-C)  
  • 3-Item Drug Use Interview | 15 min 15-30m | 2W, 3M (T), 6M, 12M | N/A |
| Consciousness and Basic Cognition | • Confusion Assessment Protocol (CAP)  
• Coma Recovery Scale Revised (CRS-R) | 15m 15-30m | 2W, 6M, 12M | N/A |
| Global Outcome | • Revised-Glasgow Outcome Scale Extended (RGOSE)  
• Expanded Disability Rating Scale Post-Acute Interview (E-DRS-PI) | 8m 5-15m | 2W, 3M (T), 6M, 12M | RGOSE only 2W (T), 3M (T), 6M (T), 12M (T) |
| Comprehensive Assessment Battery (CAB) (136-148 minutes- includes screening; excludes BTACT) | • Sections:  
  • Demographic Variables  
  • Vocational History  
  • Pre-morbid medical history  
  • Prior TBI screen  
  • Alcohol Use Disorders Identification Test (AUDIT-C)  
  • 3-Item Drug Use Interview | 15 min | 2W, 3M (T), 6M, 12M | N/A |
| Cognition | • Rey Auditory Verbal Learning Test II (RAVLT)  
• Trail Making Test (TMT)  
• Wechsler Adult Intelligence Scale IV Processing Speed Index (WAIS-IV PSI)  
• NIH Toolbox Cognitive Battery  
• Brief Test of Adult Cognition by Telephone (BTACT) | 15m 5m 4m 30m 20m | 2W, 6M, 12M | N/A |
| Post-Concussive/TBI-Related Symptoms | • Rivermead Post-Concussion Questionnaire (RPQ)  
• Participant Reported Outcome Measurement Information System Pain Intensity and Interference Instruments (PROMIS-PAIN)  
• Insomnia Severity Index | 6m 5m 3m | 2W, 3M (T), 6M, 12M | N/A |
| Participation and Quality of Life (QoL) | • Quality of Life After Brain Injury- Overall Scale (Qolibri-OS)  
• Mayo-Portland Adaptability Inventory- (MPAI4-PART)  
• Satisfaction With Life Scale (SWLS)  
• SF-12 Version 2 | 2m 5m 3m 3m | 2W, 3M (T), 6M, 12M | N/A |
| Psychological Health | • PTSD Checklist (PCL-5)  
• Brief Symptom Inventory 18 (BSI18)  
• Participant Health Questionnaire- 9 (PHQ-9)  
• Columbia Suicide Severity Rating Scale (C-SSRS)* (*Only required if ≥1 on #9 [PHQ-9] or #17 [BSI-18]) | 6m 6m 5m 5m | 2W, 3M (T), 6M, 12M | N/A |
Flexible Outcome Assessment Flowchart
The Flexible Outcome Assessment Flowchart shown below illustrates the decision rules for selection of the appropriate test battery.

On follow-up, if the 2 week (or prior assessment) was completed up to the:
1. Comprehensive Assessment Battery (CAB), then repeat CAB
2. CAP Cognitive Impairment (CAP-COG), then repeat one of the forms of the GOAT and follow flow chart
3. Coma Recovery Scale-Revised (CRS-R), then repeat CRS-R and follow step-up rules
**Test Completion Codes**

### Test Attempted and completed

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Test completed in full, in person - results valid</td>
</tr>
<tr>
<td>1.1</td>
<td>Non-standard administration – a measure normally requiring an oral response, allowed a written response, results valid</td>
</tr>
<tr>
<td>1.2</td>
<td>Non-standard administration – Other (specify):</td>
</tr>
<tr>
<td>1.3</td>
<td>Test Completed, valid administration done over the phone</td>
</tr>
</tbody>
</table>

### Test Attempted but NOT completed

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Test attempted but not completed due to cognitive/neurological reason</td>
</tr>
<tr>
<td>2.2</td>
<td>Test attempted but not completed due to non-neurological/physical reasons</td>
</tr>
<tr>
<td>2.3</td>
<td>Test attempted but not completed - participant cognitively intact enough to respond but poor effort, random responding, role response, not cooperative, refusal, intoxication</td>
</tr>
<tr>
<td>2.4</td>
<td>Test attempted but not completed due to major problems with English language proficiency (and/or Spanish language proficiency if the site can also enroll Spanish speaking subjects)</td>
</tr>
<tr>
<td>2.5</td>
<td>Test attempted but not completed due to test interrupted by illness and test could not be completed later</td>
</tr>
<tr>
<td>2.6</td>
<td>Test attempted but not completed due to logistical reasons, other reasons – site specific</td>
</tr>
</tbody>
</table>

### Test not attempted

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Test not attempted due to severity of cognitive/neurological deficits</td>
</tr>
<tr>
<td>3.2</td>
<td>Test not attempted due to non-neurological/physical reasons</td>
</tr>
<tr>
<td>3.3</td>
<td>Test not attempted - participant can respond appropriately but poor effort, not cooperative, refusal, intoxication</td>
</tr>
<tr>
<td>3.4</td>
<td>Test not attempted due to major problems with English language proficiency (and/or Spanish language proficiency if the site can also enroll Spanish speaking subjects)</td>
</tr>
<tr>
<td>3.5</td>
<td>Test not attempted due to participant illness and test could not be completed later</td>
</tr>
<tr>
<td>3.6</td>
<td>Test not attempted due to logistical reasons, other reasons – site specific</td>
</tr>
<tr>
<td>4.0</td>
<td>Test not attempted, completed or valid due to examiner error</td>
</tr>
<tr>
<td>5.0</td>
<td>Other (specify: ________________________________ )</td>
</tr>
</tbody>
</table>
Speech+GOAT+ PTA 2Wk

Patient Identification Information:

If patient has already passed the GOAT and/or PTA at a previous visit, please enter Test Completion Code 5.0 and 'passed at previous visit'.

Speech Intelligibility administered: □ Yes □ No

<table>
<thead>
<tr>
<th>Test Completion Code Speech</th>
<th>Speech Completion Code Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Test completed in full - in person</td>
<td>1.0 Test completed in full - in person</td>
</tr>
<tr>
<td>1.1 Non-standard adm - written</td>
<td>1.1 Non-standard adm - written</td>
</tr>
<tr>
<td>1.2 Non-standard adm - other</td>
<td>1.2 Non-standard adm - other</td>
</tr>
<tr>
<td>1.3 Test completed in full - by phone</td>
<td>1.3 Test completed in full - by phone</td>
</tr>
<tr>
<td>2.1 Not completed - Cognitive/neuro</td>
<td>2.1 Not completed - Cognitive/neuro</td>
</tr>
<tr>
<td>2.2 Not completed - Non-neuro/phys</td>
<td>2.2 Not completed - Non-neuro/phys</td>
</tr>
<tr>
<td>2.3 Not completed - Poor effort</td>
<td>2.3 Not completed - Poor effort</td>
</tr>
<tr>
<td>2.4 Not completed - Language</td>
<td>2.4 Not completed - Language</td>
</tr>
<tr>
<td>2.5 Not completed - Illness</td>
<td>2.5 Not completed - Illness</td>
</tr>
<tr>
<td>2.6 Not completed - Logistical</td>
<td>2.6 Not completed - Logistical</td>
</tr>
<tr>
<td>3.1 Not attempted - Cognitive/neuro</td>
<td>3.1 Not attempted - Cognitive/neuro</td>
</tr>
<tr>
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<tr>
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</tr>
<tr>
<td>3.5 Not attempted - Illness</td>
<td>3.5 Not attempted - Illness</td>
</tr>
<tr>
<td>3.6 Not attempted - Logistical</td>
<td>3.6 Not attempted - Logistical</td>
</tr>
<tr>
<td>4.0 Not attempted - Examiner error</td>
<td>4.0 Not attempted - Examiner error</td>
</tr>
<tr>
<td>5.0 Other</td>
<td>5.0 Other</td>
</tr>
</tbody>
</table>

Confounding Issues

Type of GOAT administered:

<table>
<thead>
<tr>
<th>Test Completion Code GOAT</th>
<th>Test Completion Code Written GOAT</th>
<th>Test Completion Code Modified GOAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Test completed in full - in person</td>
<td>1.0 Test completed in full</td>
<td>1.0 Test completed in full</td>
</tr>
<tr>
<td>1.1 Non-standard adm - written</td>
<td>1.1 Non-standard adm - written</td>
<td>1.1 Non-standard adm - written</td>
</tr>
<tr>
<td>1.2 Non-standard adm - other</td>
<td>1.2 Non-standard adm - other</td>
<td>1.2 Non-standard adm - other</td>
</tr>
<tr>
<td>1.3 Test completed in full - by phone</td>
<td>1.3 Test completed in full - by phone</td>
<td>1.3 Test completed in full - by phone</td>
</tr>
<tr>
<td>2.1 Not completed - Cognitive/neuro</td>
<td>2.1 Not completed - Cognitive/neuro</td>
<td>2.1 Not completed - Cognitive/neuro</td>
</tr>
<tr>
<td>2.2 Not completed - Non-neuro/phys</td>
<td>2.2 Not completed - Non-neuro/phys</td>
<td>2.2 Not completed - Non-neuro/phys</td>
</tr>
<tr>
<td>2.3 Not completed - Poor effort</td>
<td>2.3 Not completed - Poor effort</td>
<td>2.3 Not completed - Poor effort</td>
</tr>
<tr>
<td>2.4 Not completed - Language</td>
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</tr>
<tr>
<td>2.5 Not completed - Illness</td>
<td>2.5 Not completed - Illness</td>
<td>2.5 Not completed - Illness</td>
</tr>
<tr>
<td>2.6 Not completed - Logistical</td>
<td>2.6 Not completed - Logistical</td>
<td>2.6 Not completed - Logistical</td>
</tr>
<tr>
<td>3.1 Not attempted - Cognitive/neuro</td>
<td>3.1 Not attempted - Cognitive/neuro</td>
<td>3.1 Not attempted - Cognitive/neuro</td>
</tr>
<tr>
<td>3.2 Not attempted - Non-neuro/phys</td>
<td>3.2 Not attempted - Non-neuro/phys</td>
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<td>3.3 Not attempted - Poor effort</td>
</tr>
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<td>3.4 Not attempted - Language</td>
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<td>3.4 Not attempted - Language</td>
</tr>
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<td>3.5 Not attempted - Illness</td>
<td>3.5 Not attempted - Illness</td>
</tr>
<tr>
<td>3.6 Not attempted - Logistical</td>
<td>3.6 Not attempted - Logistical</td>
<td>3.6 Not attempted - Logistical</td>
</tr>
<tr>
<td>4.0 Not attempted - Examiner error</td>
<td>4.0 Not attempted - Examiner error</td>
<td>4.0 Not attempted - Examiner error</td>
</tr>
<tr>
<td>5.0 Other</td>
<td>5.0 Other</td>
<td>5.0 Other</td>
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</tbody>
</table>

Confounding Issues

PTA Administered: □ Yes □ No

<table>
<thead>
<tr>
<th>Test Completion Code PTA</th>
<th>Test Completion Code Other PTA</th>
</tr>
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<tbody>
<tr>
<td>1.0 Test completed in full - in person</td>
<td>1.0 Test completed in full - in person</td>
</tr>
<tr>
<td>1.1 Non-standard adm - written</td>
<td>1.1 Non-standard adm - written</td>
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<tr>
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<td>1.3 Test completed in full - by phone</td>
<td>1.3 Test completed in full - by phone</td>
</tr>
<tr>
<td>2.1 Not completed - Cognitive/neuro</td>
<td>2.1 Not completed - Cognitive/neuro</td>
</tr>
<tr>
<td>2.2 Not completed - Non-neuro/phys</td>
<td>2.2 Not completed - Non-neuro/phys</td>
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<tr>
<td>2.3 Not completed - Poor effort</td>
<td>2.3 Not completed - Poor effort</td>
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<td>2.4 Not completed - Language</td>
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<tr>
<td>2.6 Not completed - Logistical</td>
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<tr>
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</tr>
<tr>
<td>3.6 Not attempted - Logistical</td>
<td>3.6 Not attempted - Logistical</td>
</tr>
<tr>
<td>4.0 Not attempted - Examiner error</td>
<td>4.0 Not attempted - Examiner error</td>
</tr>
<tr>
<td>5.0 Other</td>
<td>5.0 Other</td>
</tr>
</tbody>
</table>

Confounding Issues

PTA Test Comp Code Other

PTA Confounding Issues
## Speech Intelligibility

<table>
<thead>
<tr>
<th>Date</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Time Spent</th>
</tr>
</thead>
</table>

After the participant has been greeted and oriented to the assessment, engage him or her in informal conversation to determine if expressive speech is intelligible at the sentence level. Prompt the subject to repeat the sentence, "In May the apple trees blossom" and record the response verbatim:

Was the speech intelligible?

- [ ] Yes
- [ ] No

If the subject’s verbal output is not fully intelligible (i.e., one or more words cannot be understood), instruct the participant to write the following sentence, "In May, the apple trees blossom" in the space below. Fold the page in half so the top half showing the verbal response is not visible to the participant:

Was writing legible?

- [ ] Yes
- [ ] No

## Standard GOAT

<table>
<thead>
<tr>
<th>Date</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Time Spent</th>
</tr>
</thead>
</table>

1. What is your name?  
- No Error

When were you born?  
- No Error

Where do you live?  
- No Error

2. Where are you now:  
(a) City  
- No Error

(b) Building  
- No Error

3. On what date were you admitted to the hospital?  
- No Error

How did you get here?  
- No Error

4. What is the first event you can remember after the injury?  
- No Error

Can you give some detail?  
- No Error

5. What is the last event you can recall before the injury?  
- No Error

Can you give some detail?  
- No Error

6. What time is it now?  
- No Error

- Half-hour error (-1)
- One hour error (-2)
- One and one-half hour error (-3)
- Two hour error (-4)
- Two and one-half hour + error (-5)

7. What day of the week is it?  
- No Error

8. What day of the month is it? (i.e. the date)  
- No Error

9. What is the month?  
- No Error

10. What is the year?  
- No Error
### Written GOAT

<table>
<thead>
<tr>
<th>Date</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Time Spent</th>
</tr>
</thead>
</table>

1. What is your name?  
   - No Error  
   - Error (-2)

2. When were you born?  
   - No Error  
   - Error (-4)

3. Where do you live?  
   - No Error  
   - Error (-4)

4. Where are you now:  
   (a) City  
   - No Error  
   - Error (-5)

   (b) Building  
   - No Error  
   - Error (-5)

5. On what date were you admitted to the hospital?  
   - No Error  
   - Error (-5)

6. How did you get here?  
   - No Error  
   - Error (-5)

7. What is the month?  
   - No Error  
   - Error (-5)

8. What is the year?  
   - No Error  
   - Error (-5)

   - One year error (-10)  
   - Two year error (-20)  
   - Three or more year error (-30)

### Total Error:

Total Actual Score = (100 - total error) = 100 - _____ =

If GOAT Total Actual Score ≤75, proceed to Abbreviated Battery. If GOAT > 75 complete the below question on PTA duration and proceed to Comprehensive Battery

### Modified GOAT

<table>
<thead>
<tr>
<th>Date</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Time Spent</th>
</tr>
</thead>
</table>

1. What is your name?  
   - No Error  
   - Error (-2)

2. When were you born?  
   - No Error  
   - Error (-4)

3. Where do you live?  
   - No Error  
   - Error (-4)

4. Where are you now?  
   - No Error  
   - Error (-4)

5. What city are you in right now?  
   - No Error  
   - Error (-5)

6. On what date were you admitted to the hospital?  
   - No Error  
   - Error (-5)

7. How did you get to the hospital?  
   - No Error  
   - Error (-5)

8. What time is it now?  
   - No Error  
   - Half-hour error (-1)

   - One hour error (-2)  
   - One and one-half hour error (-3)  
   - Two hour error (-4)  
   - Two and one-half hour + error (-5)

### Total Error:

Total Actual Score = (88 - total error) = 88 - _____ =

If Total Actual Score ≤60, proceed to Abbreviated Battery. If GOAT > 60 complete the below question on PTA duration and proceed to Comprehensive Battery
9. Is it am or pm?
   - Correct
   - Incorrect

10. What day of the week is it?
   - No Error
   - One day error (-1)
   - Two day error (-2)
   - Three day error (-3)
   - Four day error (-4)
   - Five day + error (-5)

11. What day of the month is it? (i.e. the date)
   - No Error
   - One day error (-1)
   - Two day error (-2)
   - Three day error (-3)
   - Four day error (-4)
   - Five day + error (-5)

12. What is the month?
   - No Error
   - One month error (-5)
   - Two month error (-10)
   - Three or more month error (-15)

13. What is the year?
   - No Error
   - One year error (-10)
   - Two year error (-20)
   - Three or more year error (-30)

Total Error:
Total Actual Score = (88 - total error) = 88 - _____ =

If Total Actual Score ≤60, proceed to Abbreviated Battery.
If GOAT>60 complete the below question on PTA duration and proceed to Comprehensive Battery

**PTA**
Complete once Standard Score > 75 or Written Score >60 or Modified Score > 60

**How long was it between the injury to when the subject started to remember things consistently/ normally?**
- Immediate
- Not immediate

# of days  # of hours  # of minutes  Other:

Only assign a Battery Group if the battery has been started

Battery Group Assigned
- Abbreviated Battery
- Comprehensive Assessment Battery
- BA

****Please return to the Subject List and select the Subject again to display the assigned Battery Group****
### GOS-E 2Wk

**Patient Identification Information**

**Date**

**Start Time**

**Stop Time**

**Time Spent**

**Test Completion Code**

<table>
<thead>
<tr>
<th>Completion Code</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Test completed in full - in person</td>
<td></td>
</tr>
<tr>
<td>1.1 Non-standard adm - written</td>
<td></td>
</tr>
<tr>
<td>1.2 Non-standard adm - other</td>
<td></td>
</tr>
<tr>
<td>1.3 Test completed in full - by phone</td>
<td></td>
</tr>
<tr>
<td>2.2 Not completed - Non-neuro/phys</td>
<td></td>
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<tr>
<td>2.3 Not completed - Poor effort</td>
<td></td>
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<tr>
<td>2.4 Not completed - Language</td>
<td></td>
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<tr>
<td>2.5 Not completed - Illness</td>
<td></td>
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<tr>
<td>2.6 Not completed - Logistical</td>
<td></td>
</tr>
<tr>
<td>3.2 Not attempted - Non-neuro/phys</td>
<td></td>
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<tr>
<td>3.3 Not attempted - Poor effort</td>
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<tr>
<td>3.4 Not attempted - Language</td>
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<tr>
<td>3.6 Not attempted - Logistical</td>
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<tr>
<td>4.0 Not attempted - Examiner error</td>
<td></td>
</tr>
<tr>
<td>5.0 Other</td>
<td></td>
</tr>
</tbody>
</table>

**Test Completion Codes**

**Completion Code Other**

**Confounding Issues**

---

**Respondent:**
- Patient alone
- Relative/friend/caretaker alone
- Patient plus relative/friend/caretaker

**Consciousness:**

1. Is the head-injured person able to obey simple commands or say any words?
- No (VS)
- Yes

Note: Anyone who shows ability to obey even simple commands or utter any word or communicate specifically in any other way is no longer considered to be in the vegetative state. The examiner should review the results of the CRS-R and consult with nursing/clinical staff before assigning a rating of vegetative state on question #1.

**Independence at home:**

2a. Is the assistance of another person at home essential every day for some activities of daily living?
- No
- Yes

Note: for a NO answer they should be able to look after themselves at home for 24 hours if necessary, though they need not actually look after themselves. Independence includes the ability to plan for and carry out the following activities: getting washed, putting on clean clothes without prompting, preparing food for themselves, dealing with callers and handling minor domestic crises. The person should be able to carry out activities without needing prompting or reminding and should be capable of being left alone overnight.

2b. Do they need frequent help of someone to be around at home most of the time?
- No (upper SD)
- Yes (lower SD)

Note: for a NO answer they should be able to look after themselves at home up to eight hours during the day if necessary, though they need not actually look after themselves.

2c. Was assistance at home essential before the injury?
- No
Independence outside home:
3a. Are they able to shop without assistance?
   No (upper SD)
   Yes
Note: this includes being able to plan what to buy, take care of money themselves and behave appropriately in public. They need not normally shop, but must be able to do so.
3b. Were they able to shop without assistance before?
   No
   Yes
4a. Are they able to travel locally without assistance?
   No (upper SD)
   Yes
Note: they may drive or use public transport to get around. Ability to use a taxi is sufficient, provided the person can phone for it themselves and instruct the driver.
4b. Were they able to travel locally without assistance before the injury?
   No
   Yes

Work:
5a. Are they currently able to work to their previous capacity?
   No
   Yes
Note: If they were working before, then their current capacity for work should be at the same level. If they were seeking work before, then the injury should not have adversely affected their chances of obtaining work or the level of work for which they are eligible. If the patient was a student before injury then their capacity for study should not have been adversely affected.
5b. How restricted are they?
   Reduced work capacity (Upper MD)
   Able to work only in a sheltered workshop or non-competitive job or currently unable to work (Lower MD)
5c. Were they either working or seeking employment before the injury (answer 'yes') or were they doing neither (answer 'no')?
   No
   Yes

Social and Leisure activities:
6a. Are they able to resume regular social and leisure activities outside home?
   No
   Yes
Note: they need not have resumed all their previous leisure activities, but should not be prevented by physical or mental impairment. If they have stopped the majority of activities because of loss of interest or motivation, then this is also considered a disability.
6b. What is the extent of restriction on their social and leisure activities?
   Participate a bit less; at least half as often as before injury (Lower GR)
   Participate much less; less than half as often (Upper MD)
   Unable to participate; rarely, if ever, take part (Lower MD)
6c. Did they engage in regular social and leisure activities outside home before the injury?
   No
   Yes

Family and friendships:
7a. Has there been family or friendship disruption due to psychological problems?
   No
   Yes
Note: typical post-traumatic personality changes are: quick temper, irritability, anxiety, insensitivity to others, mood swings, depression and unreasonable or childish behavior.
7b. What has been the extent of disruption or strain?
   Occasional - less than weekly (Lower GR)
   Frequent - once a week or more, but tolerable (Upper MD)
   Constant - daily and intolerable (Lower MD)
7c. Were there problems with family or friends before the injury?
   No
   Yes

Return to normal life:
8a. Are there any other current problems relating to the injury which affect daily life?
Note: other typical problems reported after head injury: headaches, dizziness, sensitivity to noise or light, slowness, memory failures and concentration problems.

8b. Were similar problems present before the injury?

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>No</td>
<td>Yes</td>
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</table>

Note: If there were some problems before injury, but these have become markedly worse since injury then answer ‘No’ to Q8b.

<table>
<thead>
<tr>
<th>Scoring: The patient's overall rating is based on the lowest outcome category indicated on the scale. Refer to Guidelines for further information concerning administration and scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOSE Score</strong></td>
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<table>
<thead>
<tr>
<th><strong>GOSE Audit Log</strong></th>
</tr>
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<tbody>
<tr>
<td>1. Reviewer: Record Status of Review</td>
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<td>2. Check Issue Type (all that apply)</td>
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<td>Specify other:</td>
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<td>3. Site: Select response in drop down and describe any field change(s) in the Update Log Note field.</td>
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<td>4. Reviewer: Sign off on site response &amp; CRF closed</td>
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Modified GOS-E 2Wk

Patient Identification Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Time Spent</th>
<th>Form Completion Status</th>
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<td>Incompletable - Pt Factors</td>
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</table>

Test Completion Code

- 1.0 Test completed in full
- 1.1 Non-standard adm - written
- 1.2 Non-standard adm - other
- 1.3 Test completed over the phone
- 2.1 Not completed - Cognitive/neuro
- 2.2 Not completed - Non-neuro/phys
- 2.3 Not completed - Poor effort
- 2.4 Not completed - Language
- 2.5 Not completed - Illness
- 2.6 Not completed - Logistical
- 3.1 Not attempted - Cognitive/neuro
- 3.2 Not attempted - Non-neuro/phys
- 3.3 Not attempted - Poor effort
- 3.4 Not attempted - Language
- 3.5 Not attempted - Illness
- 3.6 Not attempted - Logistical
- 4.0 Not attempted - Examiner error
- 5.0 Not attempted - Other

Test Completion Codes

Completion Code Other

Confounding Issues

The GOSE-Revised was created in an attempt to document the impact peripheral or non-CNS injuries obtained at the time of the study related injury have on the final rating. Two scores will be obtained. The first will be an ‘All’ rating which looks at the participant’s change in overall level of dependence as a function of the injury. This score will include effects of the TBI (brain) as well as peripheral injuries sustained in the same accident. The second score will remove the obvious impact of the peripheral injuries leaving the disability rating that may be due to the TBI.*

(*If a new injury occurs after the study injury, include the cumulative effects of all brain and peripheral injuries in the ‘All’ rating. The ‘TBI’ score will remove the effects of all peripheral injuries)

The same format will be applied to each set of questions. For example, the GOSE-Revised would be administered as follows for travel outside the home.

Assess any limitations with travel as always for questions 4a and 4b. If travel is limited ask,
4c. ‘Does your _____________ (broken leg) contribute to the limitations with travel?’
4d. Then, ‘If you did not have the _______________ (broken leg) do you think you would be able to travel locally without assistance?’

If travel is not limited proceed to question 5a skipping 4c and 4d.
Respondent:
- Patient alone
- Relative/friend/caretaker alone
- Patient plus relative/friend/caretaker

Peripheral Injuries
A. Did you sustain any other system injuries or peripheral injuries (e.g., fractured limbs, spinal cord injury, complications from other system surgeries, etc.) in addition to your TBI?
- No
- Yes (record all of these injuries below)
A1. Record all peripheral type injuries on the lines provided and refer to them specifically below as noted*:
(*If a new injury occurs after the study injury, record all peripheral injuries below)

Consciousness:
1. Is the head-injured person able to obey simple commands or say any words?
- No (VS)
- Yes

Note: Anyone who shows ability to obey even simple commands or utter any word or communicate specifically in any other way is no longer considered to be in the vegetative state. The examiner should review the results of the CRS-R and consult with nursing/clinical staff before assigning a rating of vegetative state on question #1.

Independence at home:
2a. Is the assistance of another person at home essential every day for some activities of daily living?
- No - go to 3a
- Yes - go to 2b

Note: For a NO answer they should be able to look after themselves at home for 24 hours if necessary, though they need not actually look after themselves. Independence includes the ability to plan for and carry out the following activities: getting washed, putting on clean clothes without prompting, preparing food for themselves, dealing with callers and handling minor domestic crises. The person should be able to carry out activities without needing prompting or reminding and should be capable of being left alone overnight.

2b. Do you need frequent help or someone to be around at home most of the time?
- No (Upper SD All)
- Yes (Lower SD All)

Note: For a NO answer they should be able to look after themselves at home up to eight hours during the day if necessary, though they need not actually look after themselves.

2c. Was assistance at home essential before the injury?
- No
- Yes

2d. Does your ______________________ (specify problem(s) identified in question “A” above – e.g., your broken leg) contribute to the limitations described here?
- No - go to 3a (TBI rating = All Rating)
- Yes - go to 2e

2e. If you did not have ______________________ (specify problem(s) identified in question “A” above), do you think the assistance of another person at home would be essential every day for some activities of daily living?
- No - go to 3a
- Yes - go to 2f

Note: For a ‘No’ answer they should be able to look after themselves at home for up to 8 hours during the day if necessary, though they need not actually look after themselves.

Independence outside home:
3a. Are you able to shop without assistance?
- No (Upper SD All)

Note: For a ‘No’ answer they should be able to look after themselves at home for 24 hours if necessary, though they need not actually look after themselves.

Independence outside home: 
3b. Were you able to shop without assistance before the injury?

- No
- Yes

3c. Does your ______________________ (specify problem(s) identified in question “A” above – e.g., your broken leg) contribute to limitations with shopping?

- No - go to 4a (TBI rating = All Rating)
- Yes - go to 3d

3d. If you did not have ______________________ (specify problem(s) identified in question “A” above), do you think you would be able to shop without assistance?

- No - (Upper SD TBI)
- Yes

4a. Are they able to travel locally without assistance?

- No (Upper SD All)
- Yes - go to 5a

Note: they may drive or use public transport to get around. Ability to use a taxi is sufficient, provided the person can phone for it themselves and instruct the driver.

4b. Were they able to travel locally without assistance before the injury?

- No
- Yes

4c. Does your ______________________ (specify problem(s) identified in question “A” above – e.g., your broken leg), contribute to limitations with travel?

- No - go to 5a (TBI rating = All Rating)
- Yes - go to 4d

4d. If you did not have ______________________ (specify problem(s) identified in question “A” above), do you think you would be able to travel locally without assistance?

- No (Upper SD TBI)
- Yes

Work:

(If the person was a student before injury, then “study” can be substituted for “work” and this section should be completed accordingly.)

5a. Were you either working or seeking employment before the injury (answer ‘yes’) or were you doing neither (answer ‘no’)? (if not considered a worker, (i.e. retired, homemaker, permanently disabled), mark 5A as “No” and 5B as “Yes”)

- No
- Yes

5b. Are you currently able to work to your previous capacity?

- No - go to 5c
- Yes - go to 6a

Note: If you were working before, then your current capacity for work should be at the same level. If you were seeking work before, then the injury should not have adversely affected your chances of obtaining work or the level of work for which you are eligible. If you were a student before the injury then your capacity for study should not have been adversely affected.

5c. How restricted are you?

- Reduced work capacity (Upper MD All)
- Able to work only in a sheltered workshop or non-competitive job or currently unable to work (Lower MD All)

5d. Does your ______________________ (specify problem(s) identified in question “A” above – e.g., your broken leg) contribute to limitations with work/school?

- No - go to 6a (TBI rating = All rating)
- Yes - go to 5e

5e. If you did not have ______________________ (specify problem(s) identified in question “A” above), do you think you would be able to work to your previous capacity?

- No - go to 5f
- Yes

5f. If you did not have ______________________ (specify problem(s) identified in question “A” above), how restricted do you think you would be?
Reduced work capacity (Upper MD TBI)
Able to work only in a sheltered workshop or non-competitive job or currently unable to work (Lower MD TBI)

Social and Leisure activities:
6a. Did you engage in regular social and leisure activities outside home before the injury?
- No
- Yes

6b. Are you able to resume regular social and leisure activities outside the home?
- No - go to 6c
- Yes - go to 7a

6c. What is the extent of restriction on your social and leisure activities?
- Participate a bit less; at least half as often as before injury (Lower GR All)
- Participate much less; less than half as often (Upper MD All)
- Unable to participate; rarely, if ever, take part (Lower MD All)

6d. Does your ________________ (specify problem(s) identified in question “A” above – e.g., your broken leg) contribute to limitations with social and leisure activities?
- No - go to 7a (TBI rating = All rating)
- Yes - go to 6e

6e. If you did not have ________________ (specify problem(s) identified in question “A” above), do you think you would be able to resume regular social and leisure activities outside the home?
- No - go to 6f
- Yes - go to 7a

6f. If you did not have ________________ (specify problem(s) identified in question “A” above), how restricted do you think you would be?
- Participate a bit less, at least half as often as before injury (Lower GR TBI)
- Participate much less, less than half as often (Upper MD TBI)
- Unable to participate, rarely, if ever, take part (Lower MD TBI)

Family and friendships:
7a. Have there been psychological problems which have resulted in ongoing family disruption or disruption to friendships?
- No - go to 8a
- Yes - go to 7b

Note: Typical post-traumatic personality changes: quick temper, irritability, anxiety, insensitivity to others, mood swings, depression, and unreasonable or childish behavior

7b. What has been the extent of disruption or strain?
- Occasional - less than weekly (Lower GR All)
- Frequent - once a week or more, but tolerable (Upper MD All)
- Constant - daily and intolerable (Lower MD All)

7c. Were there problems with family or friends before the injury?
- No
- Yes

Note: If there were some problems before injury, but these have become markedly worse since injury then answer ‘No’ to this question

7d. Does your ________________ (specify problem(s) identified in question “A” above – e.g., your broken leg) contribute to limitations with family & friendships?
- No - go to 8a (TBI rating = All rating)
- Yes - go to 7e

7e. If you did not have ________________ (specify problem(s) identified in question “A” above), do you think there would be psychological problems which result in ongoing family disruption or disruption to friendships?
- No - go to 8a
- Yes - go to 7f

7f. If you did not have ________________ (specify problem(s) identified in question “A” above), what do you think the extent of the disruption or strain would be?
- Occasional - less than weekly (Lower GR TBI)
- Frequent - once a week or more, but tolerable (Upper MD TBI)
- Constant - daily and intolerable (Lower MD TBI)

Return to normal life:
8a. Are there any other current problems relating to the injury which affect daily life?
No (Upper GR All) - End Here

Yes (Lower GR All)

Note: Other typical problems reported after head injury: headaches, dizziness, tiredness, sensitivity to noise or light, slowness, memory failures, and concentration problems

8b. Were similar problems present before the injury?
   No
   Yes

Note: If there were some problems before injury, but these have become markedly worse since injury then answer 'No' to Q8b.

8c. Does your ______________________ (specify problem(s) identified in question “A” above – e.g., your broken leg) contribute to any other current problems which affect daily life?
   No - End here (TBI rating = All rating)
   Yes - go to 8d

8d. If you did not have ______________________ (specify problem(s) identified in question “A” above), do you think you would have current problems that affect daily life?
   No (Upper GR TBI)
   Yes (Lower GR TBI)

Scoring: The patient's overall rating is based on the lowest outcome category indicated on the scale. Refer to guidelines for further information concerning administration and scoring. Record the lowest score due to all injury related limitations (GOSE-All) and the lowest score with any limitations from other system injuries removed (GOSE-TBI).

GOSE-All Score:
- 1-Dead
- 2-Vegetative State (VS)
- 3-Lower Severe Disability (Lower SD)
- 4-Upper Severe Disability (Upper SD)
- 5-Lower Moderate Disability (Lower MD)
- 6-Upper Moderate Disability (Upper MD)
- 7-Lower Good Recovery (Lower GR)
- 8-Upper Good Recovery (Upper GR)

GOSE-TBI Score:
- 1-Dead
- 2-Vegetative State (VS)
- 3-Lower Severe Disability (Lower SD)
- 4-Upper Severe Disability (Upper SD)
- 5-Lower Moderate Disability (Lower MD)
- 6-Upper Moderate Disability (Upper MD)
- 7-Lower Good Recovery (Lower GR)
- 8-Upper Good Recovery (Upper GR)

Describe the person's situation and provide details about the reasons for each GOSE rating.

GOSE Audit Log
1. Reviewer: Record Status of Review
   Reviewed- No issues, Closed
   Reviewed- Issue notes sent to site

2. Check Issue Type (all that apply)
   GOSE Point Assignment
   GOSE Inconsistent Responses
   GOSE Inconsistency with Interview
   Other (describe below)

Initials  Date

https://studydata.net/qgen/YFormPrint.php?FormName=GOSE2Wk
<table>
<thead>
<tr>
<th>Specify other:</th>
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</thead>
</table>

3. Site: Select response in drop down and describe any field change(s) in the Update Log Note field.

- Reviewed – GOSE CRF changed
- Reviewed – GOSE CRF changed & Interview CRF changed (fill in details on GOSE & Interview log note fields)
- Reviewed – Interview CRF changed (fill in details on Interview log note field)
- Reviewed – No CRF changes needed, correct as is
- Reviewed – No CRF changes needed, insufficient notes/information to update
- Reviewed – No CRF changes needed other (fill in details on log note field)

4. Reviewer: Sign off on site response & CRF closed

- Incomplete administration of measure; score may be invalid

<table>
<thead>
<tr>
<th>Initials</th>
<th>Date</th>
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### DRS Caregiver 2Wk

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<tr>
<th>Date</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Time Spent</th>
<th>Test Completion Code</th>
</tr>
</thead>
</table>

- **Responder**: Caregiver

#### Test Completion Codes

- 1.0 Test completed in full - in person
- 1.1 Non-standard adm - written
- 1.2 Non-standard adm - other
- 1.3 Test completed in full - by phone
- 2.2 Not completed - Non-neuro/phys
- 2.3 Not completed - Poor effort
- 2.4 Not completed - Language
- 2.5 Not completed - Illness
- 2.6 Not completed - Logistical
- 3.2 Not attempted - Non-neuro/phys
- 3.3 Not attempted - Poor effort
- 3.4 Not attempted - Language
- 3.5 Not attempted - Illness
- 3.6 Not attempted - Logistical
- 4.0 Not attempted - Examiner error
- 5.0 Other

#### Confounding Issues

**1.0 Eye Opening**

1.1 Does [name] usually keep eyes open during the daytime and closed at nighttime, similar to someone sleeping?

- 0-Yes
- 1-No

1.2 Does [name] open [his/her] eyes when you touch, speak, or shout to [him/her]?

- 0-Yes
- 1-No

1.3 Does [name] open eyes if you do something painful or uncomfortable such as pinch the arm or leg, or rub the chest with your knuckles?

- 0-Yes
- 1-No

**2.0 Motor Response**

2.1 Is [name] able to obey commands? For example, “Move finger”, “Point to Ceiling”, “Close eyes”, “Move lips”, “Stick tongue out”.

- 0-Yes
- 1-No

2.2 If you pinch an arm/leg hard enough to hurt, will (name):

- 0-Yes
- 1-No
- 1-Try to stop you (by grabbing/kicking your hand)
- 2-Try to move away from you
- 3-Reflexively bend the arms inward and draw shoulders forward
- 4-Reflexively stretch the arms and legs outward
- 5-Nothing

**3.0 Communication Ability**

3.1 Is [name] able to communicate with you in a way that you and others clearly understand?

- 0-Consistently
- 1-Inconsistently
- 2-No
- 0-Speech

3.2 How do they communicate primarily?
3.3 Is [name] able to give the correct date and time within a few seconds of being asked?

- Yes
- Yes, but takes more than a few seconds
- Sometimes
- No

3.4 Does [name] have only a few words that [s/he] uses over and over or does [s/he] express him/herself only through random answers, shouting or swearing?

- No
- Yes

3.5 Does [name] only moan, groan or make other sounds that are not understandable?

- No
- Yes

### 4.0 Feeding

4.1 Can [name] feed him/herself independently or manage tube feedings appropriately without help or reminders?

- Yes
- No

4.2 Does [name] understand what eating or feeding utensils or equipment are for and how they should be used?

- Always
- Most of the time
- Some of the time
- Never

4.3 Does [name] know when meal or feeding times are?

- Always
- Most of the time
- Some of the time
- Never

### 5.0 Toileting

5.1 Can [name] use the toilet or manage their bowel and bladder routine independently and appropriately without help or reminders?

- Yes
- No

5.2 Does [name] understand how to manage their clothing or special equipment when toileting or in bowel and bladder management?

- Always
- Most of the time
- Some of the time
- Never

5.3 Does [name] know when to use the toilet or to conduct bowel and bladder management?

- Always
- Most of the time
- Some of the time
- Never

### 6.0 Grooming

6.1 Can [name] dress and groom him/herself independently and appropriately or direct someone else in these activities without help or reminders?

- Yes
- No

6.2 Does [s/he] know how to bathe and wash?

- Always
- Most of the time
- Some of the time
- Never

6.3 Does [s/he] understand how to get dressed?

- Always
- Most of the time
- Some of the time
- Never

6.4 Can [s/he] start and finish these grooming activities without prompting?

- Always
- Most of the time
- Some of the time
- Never

### 7.0 Level of Functioning

7.1 Does [name] function completely independently? That is, [s/he] does not require any physical assistance, supervision, equipment, devices or reminders for cognitive, social, behavioral, emotional, and physical function?

- No
- Yes

7.2 Does [name] REQUIRE special aids or equipment such as a brace, walker,
wheelchair, memory notebook, day planner, verbal reminders, prompts, cues, or alarm watch because of a disability?

7.3 Does [name] require physical assistance from another person to meet daily needs?

- 0 - Never
- 1 - Most of the time
- 2 - Some of the time
- 3 - Always

7.4 Does [s/he] require assistance from another person in tasks that require thinking abilities?

- 0 - Never
- 1 - Some of the time
- 2 - Most of the time
- 3 - Always

7.5 Does [s/he] require assistance from another person to manage emotions and behavior?

- 0 - Never
- 1 - Some of the time
- 2 - Most of the time
- 3 - Always

7.6a Does [s/he] take care of some of their needs but also need a helper who is always close by?

- 0 - No
- 1 - Yes

7.6b Does [s/he] need help with all major activities and the assistance of another person all the time?

- 0 - No
- 1 - Yes

7.6c Does [s/he] need 24-hour care and is not able to help with their own care at all?

- 0 - No
- 1 - Yes

8.0 Employability

8.1 Can [name] function with complete independence in work or social situations?

- 0 - Always
- 1 - Most of the time
- 2 - Some of the time
- 3 - Never

8.2 Can [name] understand, remember, and follow directions?

- 0 - Always
- 1 - Most of the time
- 2 - Some of the time
- 3 - Never

8.3 Can [name] keep track of time, schedules and appointments?

- 0 - Always
- 1 - Most of the time
- 2 - Some of the time
- 3 - Never

8.4 How certain are you that [name] can perform in a wide variety of jobs of [his/her] choosing or manage a home independently or participate in school full-time?

- 0 - Certain or very certain s/he can
- 1 - Uncertain
- 2 - Certain or very certain s/he cannot

8.5 How certain are you that [name] can be successful at work, school or in home management with some reduction in the work load or with other accommodations due to disabilities?

- 0 - Certain or very certain s/he can
- 1 - Uncertain
- 2 - Certain or very certain s/he cannot

8.6 How certain are you that [name] can be successful at work, school or in home management but with limited choices in jobs or school courses due to disabilities?

- 0 - Certain or very certain s/he can
- 1 - Uncertain
- 2 - Certain or very certain s/he cannot

8.7 How certain are you that [name] can be able to work at home or in a special setting like a sheltered workshop in which the work is very routine and there is very frequent supervision and support?

- 0 - Certain or very certain s/he can
- 1 - Uncertain
<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
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<tbody>
<tr>
<td>Item 2</td>
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<td>Item 7</td>
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<td>Item 8</td>
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</table>

**DRS-PI Score**

Subtotal = DRS-PI + sum(7.1 thu 8.4):

Add score for Employment Category

**Expanded DRS-PI Score**
### Patient Identification Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Time Spent</th>
<th>Responder</th>
<th>Test Completion Code</th>
</tr>
</thead>
</table>

**Note:** There is no Item 1, the interview begins with Item 2.

#### 2.0 Communication Ability

2.3 Are you able to give the correct date and time within a few seconds of being asked?

- **0-Yes**
- **1-Yes, but takes more than a few seconds**
- **2-Sometimes**
- **3-No**

**Note:** There is no Item 3, the interview continues with Item 4.

#### 4.0 Feeding

4.1 Can you feed yourself feed independently or manage tube feedings appropriately without help or reminders?

- **0-Yes**
- **1-No**
- **0-Always**
- **1-Always**
- **2-Some of the time**
- **3-Never**

4.2 Do you understand what eating or feeding utensils or equipment are for and how they should be used?

4.3 Do you know when meal or feeding times are?

#### 5.0 Toileting

5.1 Can you use the toilet or manage your bowel and bladder routine

- **0-Yes**
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https://studydata.net/qgen/YFormPrint.php?FormName=DRSSelf2Wk
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8.3 Can you keep track of time, schedules and appointments?

8.4 How certain are you that you can perform in a wide variety of jobs of your choosing or manage a home independently or participate in school full-time?

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**SCORING COMING SOON**
Sum scores based on algorithm for items:

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<th>Item</th>
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<tbody>
<tr>
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DRS-PI Score

Subtotal = DRS-PI + sum(7.1 thru 8.4):

Add score for Employment Category

Expanded DRS-PI Score
# Interview 2Wk New

## Patient Identification Information

- [ ] Date
- [ ] Start Time
- [ ] Stop Time
- [ ] Time Spent
- [ ] Test administered in Spanish?
- [ ] Initial
- [ ] Cohort
  - CA-MRI
  - BA
  - CA-MRI-HDFT
  - CA-MRI Friend Control
  - CA Friend Control
  - CA Ortho Control
  - CA-MRI Ortho Control

## Test Completion Code

- 1.0 Test completed in full - in person
- 1.1 Non-standard adm - written
- 1.2 Non-standard adm - other
- 1.3 Test completed in full - by phone
- 2.1 Not completed - Cognitive/neuro
- 2.2 Not completed - Non-neuro/phys
- 2.3 Not completed - Poor effort
- 2.4 Not completed - Language
- 2.5 Not completed - Illness
- 2.6 Not completed - Logistical
- 3.1 Not attempted - Cognitive/neuro
- 3.2 Not attempted - Non-neuro/phys
- 3.3 Not attempted - Poor effort
- 3.4 Not attempted - Language
- 3.5 Not attempted - Illness
- 3.6 Not attempted - Logistical
- 4.0 Not attempted - Examiner error
- 5.0 Other

### Test Completion Codes

- Completion Code Other

## Confounding Issues

### 1. Information obtained:

- In-person
- By phone

### 2. Questions completed by:

- Subject alone
- Subject with confirmation by significant other
- Significant other only
- Primarily significant other with confirmation from subject

#### Significant other:

- Spouse
- Parent
- Child
- Sibling
- Grandparent
- Guardian
- Other relation

Reason significant other and why not done primarily with subject:

### 3. Have you sustained any other injuries since your study injury?

- No. Skip to question 4
- Yes

#### Explain other injury

If yes, did it involve another brain injury?

- No
- Yes
- N/A
- Unknown

Do you have current difficulties as the result of the new injury?

- No
- Yes
- N/A, no new injury
- Unknown

Please specify:
4. Where are you living now? (choose one)
- Independent, lives alone
- Independent, lives with others (spouse, significant other)
- Independent, lives with others (roommate, friend)
- Home of parents, guardians, relatives (irrespective of injury, not due to health)
- Home of parents, guardians, relatives, friends (due to injury/health, dependent due to health)
- Hospital acute care/medical ward
- Hospital – rehab ward
- Hospital – other
- Sub-acute/SNF
- Nursing home
- Group home/adult home
- Correctional
- Hotel
- Military Barracks
- Homeless
- Other
- Unknown
Other, please specify:

5. If there has been a change in your living situation (pre versus now), what is the reason? (choose one)
- Head injury
- Other system injuries related to the accident
- Both head injury and other system injuries related to the accident
- Other medical unrelated to the accident
- Financial related to the accident
- Financial unrelated to the accident
- Other
- N/A - no change
- Unknown
Other, please specify:

6. What is your current employment status?
- Working now
- Disabled, permanently or temporarily *
- Only temporarily laid off, sick leave, or maternity leave **
- Keeping house
- Looking for work, unemployed ***
- Student
- Retired
- Other, specify
- Not applicable, (still in hospital)
- Unknown
* e.g., working before the injury, not working now and no longer has a job to return to
** e.g., working before the injury, not working now due to health but still has a job to return to
*** e.g., able to work but currently unemployed
Other, please specify:

7. Which of the following were you doing last week? (choose one)
- Working for pay at a job or business
- Employed by a job or business, but not at work last week
- Looking for work
- Working, but not for pay, at a family owned job or business
- Not working at a job or business, and not looking for work
- Refused to answer
- N/A (still in hospital)
- Unknown
- Taking care of house or family
- Going to school
- Retired
- On a planned vacation from work
- On family or maternity-paternity leave
- Temporarily unable to work for health reasons
- Have a job or contract, but it is the off-season
- On lay-off or unable to find work

8. What is the main reason you did not work last week? (choose one)
9. How many hours altogether did you work in the past 7 days (fill in number of hours 1 to 98)?

10. About how many hours does your employer expect you to work in a typical 7-day week (fill in number of hours 1 to 98)?

11. If you worked less than your usual hours last week, what is the reason?

12. Since your injury, have you or someone in your family been contacted by your employer or an employer representative concerning your return to your job at the time of your injury or about other work within the same company? (Choose one)

13. Since your injury, has your employer offered you any of the following in response to any health limitations related to your injury? (Choose Yes, No, Unk (unknown) or N/A (not applicable) for each)

   (Examiner: also code ‘yes’ here if the person took advantage of an existing benefit)

   1. Sick leave
   2. Part-time or reduced hours
   3. Modified schedule
   4. Transfer to a different job with different tasks
   5. Equipment/assistive technology to help perform the job
   6. Job coaching/mentor to be able to do job
14. Did you attend school in the last week? (choose one)

- No
- Yes
- N/A

15. What is the main reason you did not attend school in the past week? (choose one)

- Other medical unrelated to the accident
- Financial unrelated to the accident
- Planned vacation/scheduled time off *
- Other
- N/A - attended school in the last week
- N/A - not a student pre-injury and no plans to attend
- Unknown
- Head injury
- Other system injuries related to the accident
- Both head injury and other system injuries related to the accident
- Financial related to the accident

* Examiners: if the person could not attend school for other reasons in addition to it being during a vacation period, choose the other reason.

Other, please specify: 

Questions 16-25 are asked if the participant has been discharged from acute care (or following their visit to the ED), otherwise skip these questions and go to question 26

Follow-up Care

16. Did you receive education materials about your injury from the hospital? (Choose one)

- No
- Yes
- Unknown

17. Were you given contact information for where to follow up with symptoms from your injury? (Choose one)

- No
- Yes
- Unknown

18. Did anyone from the hospital call you to follow up with you about your injury? (Choose one)

- No
- Yes
- Unknown

19. Have you seen any healthcare provider since your discharge from the ED or hospital for your TBI?

Type of healthcare provider: (If yes, check all that apply)

- General practitioner (primary care)
- TBI/Concussion Clinic
- Neurologist
- Physiatrist
- Chiropractor
- Psychiatrist
- Psychologist, psychological services
- Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.)
- Other

Did it help?

- No
- Yes
- Unknown

20. Did you receive education materials about your injury from the outpatient clinic? (Choose one)

- No
- Yes
- Unknown

21. Were you given contact information for where to follow up with symptoms from your injury? (Choose one)

- No
- Yes
- Unknown

22. Did anyone from the outpatient clinic call you to follow up with you about your injury? (Choose one)

- No
- Yes
- Unknown

23. Have you seen any healthcare provider since your discharge from the outpatient clinic for your TBI?

Type of healthcare provider: (If yes, check all that apply)

- General practitioner (primary care)
- TBI/Concussion Clinic
- Neurologist
- Physiatrist
- Chiropractor
- Psychiatrist
- Psychologist, psychological services
- Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.)
- Other

Did it help?

- No
- Yes
- Unknown

24. Did you receive education materials about your injury from your primary care provider? (Choose one)

- No
- Yes
- Unknown

25. Were you given contact information for where to follow up with symptoms from your injury? (Choose one)

- No
- Yes
- Unknown

26. Did anyone from your primary care provider call you to follow up with you about your injury? (Choose one)

- No
- Yes
- Unknown

27. Have you seen any healthcare provider since your discharge from your primary care provider for your TBI?

Type of healthcare provider: (If yes, check all that apply)

- General practitioner (primary care)
- TBI/Concussion Clinic
- Neurologist
- Physiatrist
- Chiropractor
- Psychiatrist
- Psychologist, psychological services
- Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.)
- Other

Did it help?

- No
- Yes
- Unknown

28. Did you receive education materials about your injury from the spouse or significant other? (Choose one)

- No
- Yes
- Unknown

29. Were you given contact information for where to follow up with symptoms from your injury? (Choose one)

- No
- Yes
- Unknown

30. Did anyone from the spouse or significant other call you to follow up with you about your injury? (Choose one)

- No
- Yes
- Unknown

31. Have you seen any healthcare provider since your discharge from the spouse or significant other for your TBI?

Type of healthcare provider: (If yes, check all that apply)

- General practitioner (primary care)
- TBI/Concussion Clinic
- Neurologist
- Physiatrist
- Chiropractor
- Psychiatrist
- Psychologist, psychological services
- Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.)
- Other

Did it help?

- No
- Yes
- Unknown

32. Did you receive education materials about your injury from the other sources? (Choose one)

- No
- Yes
- Unknown

33. Were you given contact information for where to follow up with symptoms from your injury? (Choose one)

- No
- Yes
- Unknown

34. Did anyone from the other sources call you to follow up with you about your injury? (Choose one)

- No
- Yes
- Unknown

35. Have you seen any healthcare provider since your discharge from the other sources for your TBI?

Type of healthcare provider: (If yes, check all that apply)

- General practitioner (primary care)
- TBI/Concussion Clinic
- Neurologist
- Physiatrist
- Chiropractor
- Psychiatrist
- Psychologist, psychological services
- Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.)
- Other

Did it help?

- No
- Yes
- Unknown
20. Have you seen any healthcare provider since your discharge from the ED or hospital for any peripheral injuries (e.g. fractured limbs, eye injuries, etc.)?
- No
- Yes
- Unknown

Type of healthcare provider:
(If yes, check all that apply)
- General practitioner (primary care)
- Cardiologist
- Orthopedics
- Oral and maxillofacial Surgery
- Plastic Surgery
- ENT
- Other

Did it help?
- No
- Yes
- Unknown

Other, please specify:

21. Did you receive any inpatient or outpatient rehabilitation treatment to address problems related to your brain injury following your visit to the ED/discharge from the acute care hospital? (Choose one)
- No, skip to Question 24
- Yes
- Unknown, skip to Question 24

22. Were you treated as an inpatient for problems related to your brain injury?
- No, skip to Question 23
- Yes

Start Date:
Active Inpatient Rehab Ongoing:
- No
- Yes
End Date:

At what type of facility did you receive treatment? (Check all that apply)
- Acute Care Hospital
- Long-Term Acute Care Hospital (LTACH)
- Inpatient Rehabilitation Facility (IRF)
- Skilled Nursing Facility
- Inpatient Geriatric Care Center
- Other
- Unknown

Other, please specify:

What type of therapy services did you receive? (Check all that apply)
- Physical therapy
- Occupational therapy
- Speech therapy
- Therapeutic recreation
- Cognitive remediation
- Psychological services
- Nursing services
- Peer mentoring
- Social work/Case management

- 1-2 days per week
- 3-5 days per week
### 23. Were you treated as an **outpatient** for problems related to your brain injury?  
- **No**, skip to Question 24  
- **Yes**

<table>
<thead>
<tr>
<th>Start Date:</th>
<th>Active Outpatient Rehab Ongoing</th>
<th>End Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

**At what type of facility did you receive treatment? (Check all that apply)**
- Residential Living Facility/Independent Living Center/Group Home  
- Outpatient General Medical Clinic  
- Outpatient Rehabilitation Clinic  
- Home (i.e. therapist comes to person's home)  
- Other  
- Unknown  

**Other, please specify:**

**What type of therapy services did you receive? (Check all that apply)**
- Physical therapy  
- Occupational therapy  
- Speech therapy  
- Therapeutic recreation  
- Cognitive remediation  
- Educational services  
- Vocational services  
- Psychological services  
- Nursing services  
- Peer mentoring  
- Social work/Case management  
- Independent living training  
- Home health aide  
- Other  

**Did you receive more than two different therapy services at the same time?**
- **No**  
- **Yes**  
- **Unknown**

### 24. If you **did not receive** any rehabilitation treatment to address problems related to your **brain injury** following your ED/visit/discharge from the hospital, please select your:

**Follow-up care interest level:**
- Interested in follow-up care  
- Not interested in follow-up care  
- **Other**, please specify:

**Interested in follow-up care, please check any/all of the reasons that apply:**
- but no/insufficient insurance coverage  
- but insurance coverage was denied  

---

https://studydata.net/qgen/YFormPrint.php?FormName=Interview2Wk
but could not arrange transportation
but worried about the physical (e.g. increased pain), emotional (e.g. depression, anxiety) or personal (e.g. too much time, delay in going back to work/school) consequences it might cause
but worried about the burden it would place on others close to me (e.g. cost, time, additional demands)
but treatment services have not yet been arranged
but not give any information/referral
Other

Interested in follow-up care Other, please specify:

Not Interested in follow-up care, please check any/all of the reasons that apply:
- because I did not think I needed it (e.g., Dr. said I didn’t need it and/or didn’t need a referral for that reason)
- because I believe I can manage the problems caused by my injury on my own
- because I was dissatisfied with the treatment I received at the ED/hospital

25. Did you receive any inpatient or outpatient rehabilitation for any peripheral injuries (e.g., fractured limbs, eye injuries, etc.) following your visit to the ED/discharge from the acute care hospital?

<table>
<thead>
<tr>
<th>Type of therapy: (check all that apply)</th>
<th>Did it help?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
</tr>
<tr>
<td>Other, please specify:</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Outpatient Rehabilitation

- Physical Therapy
- Occupational Therapy
- Other
- Other, please specify:

26. Overall how satisfied are you with the availability of support from people close to you since the injury?

27. Overall how satisfied are you with the help you got from people at the hospital at the time of your injury?

28. Overall how satisfied are you with the health care services you got after your hospital discharge (including rehabilitation)?

29. Do you think you need more health care services than you received?
30. Overall, how satisfied are you with the support you have received from your employer since your injury?  □ Slightly  □ Moderately  □ Quite  □ Very  □ N/A no contact with employer  □ N/A self-employed or not working  □ Unknown  □ No  □ Yes, worse in the left ear  □ Yes, worse in the right ear  □ Yes, worse in both ears  □ Unknown  □ N/A self-employed or not working

31. Since your injury, has your hearing been worse in either ear?  □ No  □ Yes, worse in the left ear  □ Yes, worse in the right ear  □ Yes, worse in both ears  □ Unknown

32. Since your injury, have you been bothered by new or worse than pre-injury ringing, roaring, buzzing or other sounds in your ears or head that lasts for 5 minutes or more?  □ Yes  □ Unknown  □ No  □ Yes  □ Unknown  □ No  □ Yes  □ Unknown

33. Since your injury, have you had a problem with dizziness, lightheadedness, feeling as if you are going to pass out or faint, unsteadiness or imbalance?  □ No  □ Yes  □ Unknown

34. Since your injury, has your ability to taste or smell changed from pre-injury?  □ No  □ Yes  □ Unknown

35. Since your injury, have you had any problems with the following?
   Voice problem  □ No  □ Yes  □ Unknown
   Swallowing problem  □ No  □ Yes  □ Unknown
   Speech problem  □ No  □ Yes  □ Unknown
   Language problem  □ No  □ Yes  □ Unknown

36. Do you currently use tobacco?  □ No  □ Yes  □ Unknown
   Type of tobacco:  
   (If yes, check all that apply)  
   □ Filtered cigarettes  □ Non-filtered cigarettes  □ Low tar cigarettes  □ Cigars  □ Pipes  □ Chewing tobacco  □ E-cigarettes  □ Other
   Other, please specify: 

37. Since the injury, how often do you have a drink containing alcohol?  □ Never  □ 1 or 2 times  □ 2-3 times a week  □ 4 or more times a week  □ Unknown  □ 1 or 2  □ 3 or 4  □ 5 or 6  □ 7 to 9  □ 10 or more  □ N/A have not had any alcohol since injury  □ Unknown  □ Never  □ Once  □ Weekly  □ Daily or almost daily  □ N/A have not had any alcohol since injury  □ Unknown

38. Since the injury, on a typical day when you are drinking, how many standard drinks containing alcohol do you have?  □ 1 or 2  □ 3 or 4  □ 5 or 6  □ 7 to 9  □ 10 or more  □ N/A have not had any alcohol since injury  □ Unknown

39. How often do you have six or more drinks on one occasion since the injury?  □ Never  □ Once  □ Weekly  □ Daily or almost daily  □ N/A have not had any alcohol since injury  □ Unknown

40. Since your injury, did you use any illicit or non-prescription drugs?  □ Yes  □ No  □ Unknown
   "We are wanting to know about drugs like marijuana, crack or heroin;"
41. Ask everyone regardless of the answer above: Did you use Marijuana? (If the answer is 'YES' then ask, 'Was Marijuana prescribed to you?')

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Synthetic drugs like ‘fake marijuana’ and ‘bath salts’</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. Prescription drugs like pain killers or stimulants not prescribed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td>Unknown</td>
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<tr>
<td>Unknown</td>
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<tr>
<td>c. Chemicals inhaled or 'huffed'</td>
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<tr>
<td>Yes</td>
<td></td>
<td></td>
<td>Unknown</td>
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<tr>
<td>Unknown</td>
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</tr>
</tbody>
</table>

42. Category of illegal drugs, prescription, or over-the-counter drugs used for purposes other than those for which they are meant to be used, or in large amounts - as described above (choose all that apply)

(If category of illegal drugs is filled out then it should also be for drugs used since the injury).

- a. Sedatives
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- b. Tranquilizers or anti-anxiety drugs
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- c. Painkillers
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- d. Stimulants
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- e. Marijuana, hash, THC, or grass
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- f. Cocaine or crack
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- g. Hallucinogens
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- h. Inhalants or solvents
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- i. Heroin
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- j. Synthetic drugs like “fake marijuana” and “bath salts”
  - No
  - Yes
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Unknown</th>
<th>Other, please specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>k. Any OTHER substances or medicines you have used to get high</td>
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<td></td>
<td>No</td>
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<td>Yes</td>
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<td></td>
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</tbody>
</table>

43. Since your injury, have you been in trouble at school, work, or with relationships because of drug use?  

- No
- Yes
- N/A (have not used any drugs including Marijuana)
- Unknown
### Interview 3Mo New

**Patient Identification Information**  

**Date** | **Start Time** | **Stop Time** | **Time Spent**  
--- | --- | --- | ---  

**Test administered in Spanish?** ☐  

**Initial Cohort**  
- CA-MRI  
- CA  
- BA  
- CA-MRI-HDFT  
- CA-MRI Friend Control  
- CA Friend Control  
- CA Ortho Control  
- CA-MRI Ortho Control  

**Test Completion Code**  
- 1.0 Test completed in full - in person  
- 1.1 Non-standard adm - written  
- 1.2 Non-standard adm - other  
- 1.3 Test completed in full - by phone  
- 2.1 Not completed - Cognitive/neuro  
- 2.2 Not completed - Non-neuro/phys  
- 2.3 Not completed - Poor effort  
- 2.4 Not completed - Language  
- 2.5 Not completed - Illness  
- 2.6 Not completed - Logistical  
- 3.1 Not attempted - Cognitive/neuro  
- 3.2 Not attempted - Non-neuro/phys  
- 3.3 Not attempted - Poor effort  
- 3.4 Not attempted - Language  
- 3.5 Not attempted - Illness  
- 3.6 Not attempted - Logistical  
- 4.0 Not attempted - Examiner error  
- 5.0 Other  

**Completion Code Other**  

**Confounding Issues**  

1. **Information obtained:**  
   - ☐ In-person  
   - ☐ By phone  

2. **Questions completed by:**  
   - ☐ Subject alone  
   - ☐ Subject with confirmation by significant other  
   - ☐ Significant other only  
   - ☐ Primarily significant other with confirmation from subject  
   - ☐ Significant other:  
     - ☐ Spouse  
     - ☐ Parent  
     - ☐ Child  
     - ☐ Sibling  
     - ☐ Grandparent  
     - ☐ Guardian  
     - ☐ Other relation  
   - Reason significant other and why not done primarily with subject:  

3. **Have you sustained any other injuries since your study injury?**  
   - ☐ No. Skip to question 4  
   - ☐ Yes  
   - ☐ Unknown. Skip to question 4  

   **Explain other injury**  

4. **If yes, did it involve another brain injury?**  
   - ☐ No  
   - ☐ Yes  
   - ☐ N/A  
   - ☐ Unknown  

5. **Do you have current difficulties as the result of the new injury?**  
   - ☐ No  
   - ☐ Yes  
   - ☐ N/A, no new injury  
   - ☐ Unknown  

   **Please specify:**  

---

https://studydata.net/qgen/YFormPrint.php?FormName=Interview3Mo
4. Where are you living now? (choose one)
- Independent, lives alone
- Independent, lives with others (spouse, significant other)
- Independent, lives with others (roommate, friend)
- Home of parents, guardians, relatives (irrespective of injury, not due to health)
- Home of parents, guardians, relatives, friends (due to injury/health, dependent due to health)
- Hospital acute care/medical ward other partner
- Hospital – rehab ward
- Hospital – other
- Sub-acute/SNF
- Nursing home
- Group home/adult home
- Correctional
- Hotel
- Military Barracks
- Homeless
- Other
- Unknown
Other, please specify:

5. If there has been a change in your living situation (pre versus now), what is the reason? (choose one)
- Head injury
- Other system injuries related to the accident
- Both of the above
- Other medical unrelated to the accident
- Financial related to the accident
- Financial unrelated to the accident
- N/A - no change
- Other
- Unknown
Other, please specify:

6. What is your current employment status?
- Working now
- Disabled, permanently or temporarily*
- Only temporarily laid off, sick leave, or maternity leave**
- Keeping house
- Looking for work, unemployed***
- Student
- Retired
- Other
- N/A (still in hospital)
- Unknown
* e.g., working before the injury, not working now and no longer has a job to return to
** e.g., working before the injury, not working now due to health but still has a job to return to
*** e.g., able to work but currently unemployed
Other, please specify:

7. Which of the following were you doing last week? (choose one)
- Working for pay at a job or business
- Employed by a job or business, but not at work last week
- Looking for work
- Working, but not for pay, at a family owned job or business
- Not working at a job or business, and not looking for work
- Refused to answer
- N/A (still in hospital)
- Unknown
- Taking care of house or family
- Going to school
- Retired
- On a planned vacation from work
- On family or maternity-paternity leave
- Temporarily unable to work for health reasons
- Have a job or contract, but it is the off-season
- On lay-off or unable to find work

8. What is the main reason you did not work last week? (choose one)
9. How many hours altogether did you work in the past 7 days (fill in number of hours 1 to 98)?

10. About how many hours does your employer expect you to work in a typical 7-day week (fill in number of hours 1 to 98)?

11. If you worked less than your usual hours last week, what is the reason?

Health limitations resulting from the TBI
Health limitations from other medical conditions related to the study injury
Both of the above
Health limitations from other medical condition unrelated to the study injury
Took time off for personal reasons unrelated to health
Lack of available hours or shifts
Other
N/A, worked usual number of hours last week
N/A, was not a worker before injury and am not a worker now
Unknown
Specify Other

12. Since your injury, have you or someone in your family been contacted by your employer or an employer representative concerning your return to your job at the time of your injury or about other work within the same company? (Choose one)

No
Yes
N/A self-employed or not working
Unknown

13. In the last two months, has your employer offered you any of the following in response to any health limitations related to your injury? (Check yes, No, Unk (unknown) or N/A (not applicable) for each)
(Examiner: also code 'yes' here if the person took advantage of an existing benefit)

1. Sick leave

2. Part-time or reduced hours

3. Modified schedule

4. Transfer to a different job with different tasks

5. Equipment/assistive technology to help perform the job

6. Job coaching/mentor to be able to do job
14. Did you attend school in the last week? (choose one)

15. What is the main reason you did not attend school in the past week? (choose one)

Questions 16 – 18 are asked only if they were not answered at 2 weeks. If the questions were answered at 2 weeks, skip to question 19.

16. Did you receive education materials about your injury from the hospital? (Choose one)

17. Were you given contact information for where to follow up with symptoms from your injury? (Choose one)

18. Did anyone from the hospital call you to follow up with you about your injury? (Choose one)

19. Have you seen any healthcare provider within the last 3 months for your traumatic brain injury?

Type of healthcare provider:
(If yes, check all that apply)

General practitioner (primary care)

TBI/Concussion Clinic

Neurologist

Physiatrist

Chiropractor

Psychiatrist

Psychologist, psychological services

Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.)

Other

Did it help?

No

Yes

Unknown

20. Have you seen any healthcare provider in the last 3 months
for any peripheral injuries (e.g. fractured limbs, eye injuries, etc.)?  
- Yes
- Unknown

<table>
<thead>
<tr>
<th>Type of healthcare provider: (If yes, check all that apply)</th>
<th>Did it help?</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner (primary care)</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Cardiologist</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Oral and maxillofacial Surgery</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
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<tr>
<td>Plastic Surgery</td>
<td>No</td>
</tr>
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<td></td>
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<tr>
<td></td>
<td>Unknown</td>
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<tr>
<td>Other, please specify:</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
</tbody>
</table>

21. Did you receive any inpatient or outpatient rehabilitation treatment to address problems related to your brain injury? (Choose one)
- No, skip to Question 24
- Yes
- Unknown, skip to Question 24

22. Were you treated as an **inpatient** for problems related to your brain injury?  
- No, skip to Question 23
- Yes

How long did you receive treatment?
- < 2 weeks
- 2-4 weeks
- 5-8 weeks
- 9-12 weeks
- > 12 weeks
- Active inpatient rehab ongoing
- Unknown

At what type of facility did you receive treatment?  
(Check all that apply)
- Acute Care Hospital
- Long-Term Acute Care Hospital (LTACH)
- Inpatient Rehabilitation Hospital (IRF)
- Skilled Nursing Facility
- Inpatient Geriatric Care Center
- Other
- Unknown

Other, please specify:

What type of therapy services did you receive?
- Physical therapy
  - No
  - Yes
  - Unknown

- Occupational therapy
  - No
  - Yes
  - Unknown

- Speech therapy
  - No
  - Yes
  - Unknown

- Therapeutic recreation
  - No
  - Yes
  - Unknown

- Cognitive remediation
  - No
  - Yes
  - Unknown

- Psychological services
  - No
  - Yes
  - Unknown

- Nursing services
  - No
  - Yes
<table>
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<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you receive more than two different therapy services at the same time?</td>
<td>No, Yes, Unknown</td>
</tr>
<tr>
<td>Were you treated as an <strong>outpatient</strong> for problems related to your brain injury?</td>
<td>No, Yes, Unknown, skip to Question 24</td>
</tr>
<tr>
<td>How long did you receive treatment?</td>
<td>&lt; 2 weeks, 2-4 weeks, 5-8 weeks, 9-12 weeks, &gt; 12 weeks, Active outpatient rehab ongoing, Unknown</td>
</tr>
<tr>
<td>At what type of facility did you receive treatment? (Check all that apply)</td>
<td>Residential Living Facility/Independent Living Center/Group Home, Outpatient General Medical Clinic, Outpatient Rehabilitation Clinic, Unknown, Home (i.e. therapist comes to person's home), Other, Unknown, Other, please specify:</td>
</tr>
<tr>
<td>What type of therapy services did you receive? (Check all that apply)</td>
<td>No, Yes, Unknown</td>
</tr>
</tbody>
</table>

- **Physical therapy**
- **Occupational therapy**
- **Speech therapy**
- **Therapeutic recreation**
- **Cognitive remediation**
- **Educational services**
- **Vocational services**
- **Psychological services**
- **Nursing services**
- **Peer mentoring**
- **Social work/Case management**
- **Independent living training**
Home health aide
Other

Did you receive more than two different therapy services at the same time?
No
Yes
Unknown

Examiners—only ask this question if it wasn’t answered at 2 weeks, if it was answered then go to question 25
24. If you did not receive any rehabilitation treatment to address problems related to your brain injury following your ED/visit/discharge from the hospital, please select your:

Follow-up care interest level:
Interested in follow-up care
Not interested in follow-up care
Unknown

Interested in follow-up care, please check any/all of the reasons that apply:
but no/insufficient insurance coverage
but insurance coverage was denied
but could not arrange transportation
but worried about the physical (e.g. increased pain), emotional (e.g. depression, anxiety) or personal (e.g. too much time, delay in going back to work/school) consequences it might cause
but worried about the burden it would place on others close to me (e.g. cost, time, additional demands)
but treatment services have not yet been arranged
but not give any information/referral
Other

Not Interested in follow-up care, please check any/all of the reasons that apply:
because I did not think I needed it (e.g., Dr. said I didn’t need it and/or didn’t need a referral for that reason)
because I believe I can manage the problems caused by my injury on my own
because I was dissatisfied with the treatment I received at the ED/hospital

25. Did you receive any inpatient or outpatient rehabilitation for any peripheral injuries (e.g., fractured limbs, eye injuries, etc.) in the last 3 months?
No
Yes
Unknown

If so, how long?
< 2 weeks
2-4 weeks
5-8 weeks
9-12 weeks
> 12 weeks
Active rehab ongoing
Unknown

Did it help?
No
Yes
Unknown

Type of therapy:
(check all that apply)

Inpatient Rehabilitation
Physical Therapy
No
Yes
Unknown

Occupational Therapy
No
Yes
Unknown

Other
Unknown

Outpatient Rehabilitation

Other, please specify:
No
Yes
Unknown
<table>
<thead>
<tr>
<th>26.</th>
<th>Overall how satisfied are you with the availability of support from people close to you over the last month?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
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<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>27.</th>
<th>Overall how satisfied are you with the health care services you got after your hospital discharge (including rehabilitation)?</th>
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</thead>
<tbody>
<tr>
<td></td>
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<tr>
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<td>No</td>
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<thead>
<tr>
<th>28.</th>
<th>Do you think you need more health care services than you received?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>29.</th>
<th>Overall, how satisfied are you with the support you have received from your employer since your injury?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

**Hearing/Speech Questions**

<table>
<thead>
<tr>
<th>30.</th>
<th>In the past week, has your hearing been worse than prior to your injury in either ear?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>31.</th>
<th>In the past week, have you been bothered by new or worse than pre-injury ringing, roaring, buzzing or other sounds in your ears or head that lasts for 5 minutes or more?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>32.</th>
<th>In the past week, have you had a problem with dizziness, lightheadedness, feeling as if you are going to pass out or faint, unsteadiness or imbalance?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>33.</th>
<th>In the past week, has your ability to taste or smell changed from pre-injury?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>34.</th>
<th>In the past week, have you had any problems with the following?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Voice problem</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>35.</th>
<th>Do you currently use tobacco?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

**Type of tobacco:**

(If yes, check all that apply)
36. Have you used tobacco in the 12 months prior to your injury?  □ No  □ Yes  □ Unknown

Examiner: only ask this question if it was not answered at enrollment, if it has already been answered skip to Question 37

37. In the last month, how often do you have a drink containing alcohol?
   □ Never  □ 1 or 2 times  □ 1 time a week  □ 2-3 times a week  □ 4 or more times a week  □ Unknown

38. In the last month, on a typical day when you are drinking, how many standard drinks containing alcohol do you have?
   □ 1 or 2  □ 3 or 4  □ 5 or 6  □ 7 to 9  □ 10 or more  □ N/A have not had any alcohol since injury  □ Unknown

39. In the last month, how often do you have six or more drinks on one occasion since the injury?
   □ Never  □ Once  □ Weekly  □ Daily or almost daily  □ N/A have not had any alcohol since injury  □ Unknown

40. In the last month, did you use any illicit or non-prescription drugs? 'We are wanting to know about drugs like marijuana, crack or heroin; synthetic drugs like fake marijuana and bath salts, prescription drugs like pain killers or stimulants that were not prescribed to you, or chemicals you might have inhaled or 'huffed'. We also want to know if sometimes you took more than you should have of any drugs that have been prescribed to you.'
   □ No  □ Yes  □ Unknown

41. Ask everyone regardless of the answer above: Did you use Marijuana? (If the answer is 'YES' then ask, 'Was Marijuana prescribed to you?)
   □ No  □ Yes (Used Marijuana that was prescribed)  □ Yes (used Marijuana that was NOT prescribed)*  □ Unknown

   * (Note, if both prescribed and not prescribed code = not prescribed)

42. Category of illegal drugs, prescription, or over-the-counter drugs used for purposes other than those for which they are meant to be used, or in large amounts - as described above in the last month (choose all that apply)

   (If category of illegal drugs is filled out then it should also be for drugs used since the injury).
   □ Sedatives  □ No  □ Yes  □ N/A (Not applicable (have not used any drugs including...
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Marijuana</td>
<td>Unknown</td>
</tr>
<tr>
<td>b.</td>
<td>Tranquilizers or anti-anxiety drugs</td>
<td>Yes</td>
</tr>
<tr>
<td>c.</td>
<td>Painkillers</td>
<td>No</td>
</tr>
<tr>
<td>d.</td>
<td>Stimulants</td>
<td>Yes</td>
</tr>
<tr>
<td>e.</td>
<td>Marijuana, hash, THC, or grass</td>
<td>No</td>
</tr>
<tr>
<td>f.</td>
<td>Cocaine or crack</td>
<td>Yes</td>
</tr>
<tr>
<td>g.</td>
<td>Hallucinogens</td>
<td>Yes</td>
</tr>
<tr>
<td>h.</td>
<td>Inhalants or solvents</td>
<td>Yes</td>
</tr>
<tr>
<td>i.</td>
<td>Heroin</td>
<td>Yes</td>
</tr>
<tr>
<td>j.</td>
<td>Synthetic drugs like “fake marijuana” and “bath salts”</td>
<td>Yes</td>
</tr>
<tr>
<td>k.</td>
<td>Any OTHER substances or medicines you have used to get high</td>
<td>Yes</td>
</tr>
</tbody>
</table>

43. In the last month, have you been in trouble at school, work, or with relationships because of drug use?  
- [ ] No  
- [ ] Yes  
- [ ] N/A (have not used any drugs including Marijuana)  
- [ ] Unknown
### Interview 6Mo New

**Patient Identification Information**

<table>
<thead>
<tr>
<th>Date</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Time Spent</th>
</tr>
</thead>
</table>

**Test administered in Spanish?**

- Initial

**Cohort**

- CA-MRI
- CA
- BA
- CA-MRI-HDFT
- CA-MRI Friend Control
- CA Friend Control
- CA Ortho Control
- CA-MRI Ortho Control

**Test Completion Code**

- 1.0 Test completed in full - in person
- 1.1 Non-standard adm - written
- 1.2 Non-standard adm - other
- 1.3 Test completed in full - by phone
- 2.1 Not completed - Cognitive/neuro
- 2.2 Not completed - Non-neuro/phys
- 2.3 Not completed - Poor effort
- 2.4 Not completed - Language
- 2.5 Not completed - Illness
- 2.6 Not completed - Logistical
- 3.1 Not attempted - Cognitive/neuro
- 3.2 Not attempted - Non-neuro/phys
- 3.3 Not attempted - Poor effort
- 3.4 Not attempted - Language
- 3.5 Not attempted - Illness
- 3.6 Not attempted - Logistical
- 4.0 Not attempted - Examiner error
- 5.0 Other

Follow-up Pre-Assessment Questions:

1. **Information obtained:**
   - ☐ In-person
   - ☐ By phone
   - ☐ Subject alone
   - ☐ Subject with confirmation by significant other
   - ☐ Significant other only
   - ☐ Primarily significant other with confirmation from subject

   **Significant other:**
   - ☐ Spouse
   - ☐ Parent
   - ☐ Child
   - ☐ Sibling
   - ☐ Grandparent
   - ☐ Guardian
   - ☐ Other relation

   **Reason significant other and why not done primarily with subject:**

2. **Questions completed by:**
   - ☐ Subject alone
   - ☐ Subject with confirmation by significant other
   - ☐ Significant other only
   - ☐ Primarily significant other with confirmation from subject

3. **Have you sustained any other injuries since your study injury?**
   - ☐ No. Skip to question 4
   - ☐ Yes
   - ☐ Unknown. Skip to question 4

   **Explain other injury**

4. **If yes, did it involve another brain injury?**
   - ☐ No
   - ☐ Yes
   - ☐ N/A
   - ☐ Unknown

5. **Do you have current difficulties as the result of the new injury?**
   - ☐ No
   - ☐ Yes
   - ☐ N/A, no new injury
   - ☐ Unknown
   
   **Please specify:**
When did the new injury (brain or other injury) occur?

4. Where are you living now? (choose one)

- Independent, lives alone
- Independent, lives with others (spouse, significant other, adult children)
- Independent, lives with others (roommate, friend)
- Home of parents, guardians, relatives (irrespective of injury, not due to health)
- Home of parents, guardians, relatives, friends (due to injury/health, dependent due to health)
- Hospital acute care/medical ward other partner
- Hospital – rehab ward
- Hospital – other
- Sub-acute/SNF
- Nursing home
- Group home/adult home
- Correctional
- Hotel
- Military Barracks
- Homeless
- Other
- Unknown

Other, please specify:

5. If there has been a change in your living situation (pre versus now), what is the reason? (choose one)

- Head injury
- Other system injuries related to the accident
- Both head injury and other system injuries related to the accident
- Other medical unrelated to the accident
- Financial related to the accident
- Financial unrelated to the accident
- Other
- Not applicable
- Unknown

Other, please specify:

6. What is your current employment status? (choose one)

- Working now
- Disabled, permanently or temporarily
- Only temporarily laid off, sick leave, or maternity leave
- Keeping house
- Looking for work, unemployed
- Student
- Retired
- Other
- Not applicable (still in hospital)
- Unknown

* e.g., working before the injury, not working now and no longer has a job to return to
** e.g., working before the injury, not working now due to health but still has a job to return to
*** e.g., able to work but currently unemployed

Other, please specify:

7. Which of the following were you doing last week? (choose one)

- Working for pay at a job or business
- Employed by a job or business, but not at work last week
- Looking for work
- Working, but not for pay, at a family owned job or business
- Not working at a job or business, and not looking for work
- Refused to answer
- Not applicable (still in hospital)
- Unknown

Other, please specify:

8. What is the main reason you did not work last week? (choose one)

- Taking care of house or family
- Going to school
- Retired
- On a planned vacation from work
- On family or maternity-paternity leave
- Temporarily unable to work for health reasons
- Have a job or contract, but it is the off-season
- On lay-off or unable to find work
- Disabled
- Other
- Refused
9. How many hours altogether did you work in the past 7 days (fill in number of hours 1 - 98)?

Or choose one below:
- N/A not a worker pre-injury
- N/A have not worked in the past 7 days
- N/A still in hospital
- Unknown

Other, please specify: ____________________________

10. About how many hours does your employer expect you to work in a typical 7-day week (fill in number of hours 1 - 98)?

Or choose one below:
- N/A not a worker pre-injury
- N/A have not worked in the past 7 days
- N/A still in hospital
- Unknown

11. If you worked less than your usual hours last week, what is the reason?

- Health limitations resulting from the TBI
- Health limitations from other medical conditions related to the study injury
- Both of the above
- Health limitations from other medical condition unrelated to the study injury
- Took time off for personal reasons unrelated to health
- Lack of available hours or shifts
- Other
- N/A, worked usual number of hours last week
- N/A, was not a worker before injury and am not a worker now
- Unknown

Specify Other: ____________________________

Examiner: Questions 12a & 12b ask about entire work days missed and Questions 12c & 12d ask about partial work days missed. Entire work day is defined as the number of hours the person is normally expected to work (e.g., a 4 hour work day is typically an entire work day for someone who works part-time and an 8 hour work day is an entire work day for a full time worker). Work days that are missed partially or entirely but later the missed time is made up are still counted in Questions 12a-d. Note that Questions 12c & d are for work days that are partially missed only (entire work days missed are just counted under 12a & 12b).

12. Now please think of your work experiences over the past 4 weeks (28 days). In the spaces below, provide the number of days you spent in each of the following work situations. In the past 4 weeks (28 days), how many days did you…….

   a. …miss an entire work day because of problems with your physical or mental health

   (Please include only days missed for your own health, not someone else’s health)

   Number of days missed: (range 0 – 28) (or choose one below)
   - ____________________________
   - Or:
     - N/A have not worked in the past 4 weeks (28 days)*
     - Unknown
     * (i.e. not in work force - retired, student, homemaker)

   b. …miss an entire work day for any other reason (including vacation)?

   Number of days missed: (range 0 – 28) (or choose one below)
   - ____________________________
   - Or:
     - N/A have not worked in the past 4 weeks (28 days)*
     - Unknown
     * (i.e. not in work force - retired, student, homemaker)

   c. …miss part of a work day because of problems with your physical or mental health

   (Please include only days missed for your own health, not someone else’s health)

   Number of days missed: (range 0 – 28) (or choose one below)
   - ____________________________
   - Or:
     - N/A have not worked in the past 4 weeks (28 days)*
     - Unknown
     * (i.e. not in work force - retired, student, homemaker)

   d. …miss part of a work day for any other reason (including vacation)?

   Number of days missed: (range 0 – 28) (or choose one below)
   - ____________________________
   - Or:
     - N/A have not worked in the past 4 weeks (28 days)*
     - Unknown
     * (i.e. not in work force - retired, student, homemaker)
e. …come in early, go home late, or work on your day off?

f. When you missed an entire work day because of problems with your physical or mental health, was this related to your head injury?

N/A have not worked in the past 4 weeks (28 days)*
Unknown
*(i.e. not in work force - retired, student, homemaker)

Number of days: (range 0 – 28) (or choose one below)

Or:
N/A have not worked in the past 4 weeks (28 days)*
N/A have not worked in the past 4 Weeks (28 days) (worker pre and/or post)
Unknown
*(i.e. not in work force - retired, student, homemaker)

g. When you missed part of an entire work day because of problems with your physical or mental health, was this related to your head injury?

N/A have not worked in the past 4 weeks (28 days) *
Unknown
*(worker pre and/or post injury)

13. About how many hours altogether did you work in the past 4 weeks (28 days)? (e.g., working full-time for 4 weeks = 160 hours)

Number of hours worked
Or:
Refused
N/A (i.e not in work force - retired, student, homemaker)
Unknown
*(worker pre and/or post injury)

14. On a scale from 0 to 10 where 0 is the worst job performance anyone could have at your job and 10 is the performance of a top worker, how would you rate the usual performance of most workers in a job similar to yours? (i.e., compared to others with similar job requirements)

Or:
Refused
N/A (i.e not in work force - retired, student, homemaker)
Unknown
*(worker pre and/or post injury)

15. Using the same 0 to 10 scale, how would you rate your overall performance during the past 4 weeks (28 days)?

Or:
Refused
N/A (i.e not in work force - retired, student, homemaker)
Unknown
*(worker pre and/or post injury)

16. In the last two months, has your employer offered you any of the following in response to any health limitations related to your injury? (Check No, Yes, Unk (unknown) or N/A (not applicable) for each)

Examiner: also code ‘yes’ here if the person took advantage of an existing benefit
1. Sick leave

2. Part-time or reduced hours

3. Modified schedule
4. Transfer to a different job with different tasks

5. Equipment/assistive technology to help perform the job

6. Job coaching/mentor to be able to do job

17. Did you attend school in the last week? (choose one)

18. What is the main reason you did not attend school in the past week? (choose one)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Yes</th>
<th>N/A</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head injury</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other system injuries related to the accident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both head injury and other system injuries related to the accident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other medical unrelated to the accident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial related to the accident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial unrelated to the accident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned vacation/scheduled time off</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A - attended school in the last week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A - not a student pre-injury and no plans to attend</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Examiners: if the person could not attend school for other reasons in addition to it being during a vacation period choose the other reason

Other, please specify:

Questions 19 – 21 are asked only if they were not answered at 2 weeks or 3 months. If the questions were answered before, skip to question 22

Follow-up Care

19. Did you receive education materials from the hospital where you were treated for your injury? Choose one:

<table>
<thead>
<tr>
<th>Choice</th>
<th>Yes</th>
<th>N/A</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. Were you given contact information for where to follow up with symptoms from your injury? (choose one)

<table>
<thead>
<tr>
<th>Choice</th>
<th>Yes</th>
<th>N/A</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. Did anyone from the hospital call you to follow up with you about your injury? (choose one)

<table>
<thead>
<tr>
<th>Choice</th>
<th>Yes</th>
<th>N/A</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22. Have you seen any healthcare provider since your last study visit for your traumatic brain injury?

<table>
<thead>
<tr>
<th>Type of clinician care: (If yes, check all that apply)</th>
<th>Did it help?</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner (primary care)</td>
<td>No</td>
</tr>
<tr>
<td>TBI/Concussion Clinic</td>
<td>Yes</td>
</tr>
<tr>
<td>Neurologist</td>
<td>Unknown</td>
</tr>
<tr>
<td>Physiatrist</td>
<td>No</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
23. Have you seen any healthcare provider since your last study visit for any peripheral injuries (e.g. fractured limbs, eye injuries, etc.)?  

- Yes  
- No  
- Unknown

**Type of clinician care:**  
(If yes, check all that apply)  

- General practitioner (primary care)  
- Cardiologist  
- Orthopedics  
- Oral and maxillofacial Surgery  
- Plastic Surgery  
- ENT  
- Other

**Did it help?**  

- No  
- Yes  
- Unknown

24. Did you receive any inpatient or outpatient rehabilitation treatment to address problems related to your brain injury within the last 3 months? (choose one)  

- No, skip to Question 27  
- Yes  
- Unknown, skip to Question 27

25. Were you treated as an *inpatient* to address problems related to your brain injury within the last 3 months?  

- No, skip to Question 26  
- Yes

**How long did you receive treatment?**  

- < 2 weeks  
- 2-4 weeks  
- 5-8 weeks  
- 9-12 weeks  
- > 12 weeks  
- Active inpatient rehab ongoing  
- Unknown

**At what type of facility did you receive treatment? (Check all that apply)**  

- Acute Care Hospital  
- Long-Term Acute Care Hospital (LTACH)  
- Inpatient Rehabilitation Hospital (IRF)  
- Skilled Nursing Facility  
- Inpatient Geriatric Care Center  
- Other  
- Unknown

**Other, please specify:**

**What type of therapy services did you receive?**  

- Physical therapy  
- Occupational therapy
26. Were you treated as an outpatient for problems related to your brain injury? 

- Yes
- No
- Unknown

How long did you receive treatment?

- < 2 weeks
- 2-4 weeks
- 5-8 weeks
- 8-12 weeks
- > 12 weeks
- Active outpatient rehab ongoing
- Unknown

At what type of facility did you receive treatment? (Check all that apply)

- Residential Living Facility/Independent Living Center/Group Home
- Outpatient General Medical Clinic
- Outpatient Rehabilitation Clinic
- Home (i.e. therapist comes to person's home)
- Other
- Unknown

Other, please specify:

What type of therapy services did you receive? (Check all that apply)

Physical therapy

- No
- Yes
- Unknown

Occupational therapy

- No
- Yes
- Unknown

Speech therapy

- No
- Yes
- Unknown

Therapeutic recreation

- No
- Yes
- Unknown

Cognitive remediation

- No
- Yes
- Unknown

Psychological services

- No
- Yes
- Unknown

Nursing services

- No
- Yes
### Peer mentoring
- Unknown
- No
- Yes
- Unknown

### Social work/Case management
- Unknown
- No
- Yes
- Unknown

### Independent living training
- Unknown
- No
- Yes
- Unknown

### Other
- Unknown
- No
- Yes
- Unknown

**Did you receive more than two different outpatient therapy services at the same time?**
- No
- Yes
- Unknown

---

Examiners—only ask this question if it wasn’t answered at 2 weeks or 3 months, if it was answered than go to question 28

27. If you **did not receive** any rehabilitation treatment to address problems related to your **brain injury** following your ED/visit/discharge from the hospital, please select your:

<table>
<thead>
<tr>
<th>Follow-up care interest level</th>
<th>Other reason Other, please specify:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interested in follow-up care</td>
<td></td>
</tr>
<tr>
<td>Not interested in follow-up care</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>

Interested in follow-up care, please check any/all of the reasons that apply:
- but no/insufficient insurance coverage
- but insurance coverage was denied
- but could not arrange transportation
- but worried about the physical (e.g. increased pain), emotional (e.g. depression, anxiety) or personal (e.g. too much time, delay in going back to work/school) consequences it might cause
- but worried about the burden it would place on others close to me (e.g. cost, time, additional demands)
- but treatment services have not yet been arranged
- but not give any information/referral
- Other

Interested in follow-up care Other, please specify:

Not interested in follow-up care Other, please specify:

---

28. Did you receive any inpatient or outpatient rehabilitation for any peripheral injuries (e.g., fractured limbs, eye injuries, etc.) within the last 3 months?
- No, skip to Question 29
- Yes
- Unknown, skip to Question 29

**If so, how long?**
- < 2 weeks
- 2-4 weeks
- 5-8 weeks
- 9-12 weeks
- > 12 weeks
- Active rehab ongoing
- Unknown

**Did it help?**

**Type of therapy:**
(check all that apply)

**Inpatient Rehabilitation**
- Physical Therapy
  - No
  - Yes
  - Unknown
- Occupational Therapy
  - No
  - Yes
  - Unknown
- Other
29. Overall how satisfied are you with the availability of support from people close to you over the last 3 months?

30. Overall how satisfied are you with the health care services you got after your hospital discharge (including rehabilitation)?

31. Do you think you need more health care services than you received so far?

32. Overall, how satisfied are you with the support you have received from your employer since your injury?

Hearing/Speech Questions

33. In the past week, has your hearing been worse than prior to your injury in either ear?

34. In the past week, have you been bothered by new or worse than pre-injury ringing, roaring, buzzing or other sounds in your ears or head that lasts for 5 minutes or more?

35. In the past week, have you had a problem with dizziness, lightheadedness, feeling as if you are going to pass out or faint, unsteadiness or imbalance?

36. In the past week, has your ability to taste or smell changed from pre-injury?

37. In the past week, have you had any problems with the following?
   a. Voice problem
   b. Swallowing problem
   c. Speech problem
   d. Language problem

Caregiver Time
38. We need to understand difficulties people may have with various activities because of a health or physical problem. Please tell me whether you require help doing everyday activities such as the following: getting across a room, dressing, bathing, eating, getting (in/out of) bed, using the toilet, preparing meals, shopping for groceries, making telephone calls, taking your medications, managing your money.

39. Who most often helps you with these tasks?

- No (skip to Question #40)
- Yes
- Unknown (skip to Question #40)
- Refused

40. Do you currently use tobacco?

- No
- Yes
- Unknown

Type of tobacco: (If yes, check all that apply)

- Filtered cigarettes
- Non-filtered cigarettes
- Low tar cigarettes
- Cigars
- Pipes
- Chewing tobacco
- E-cigarettes
- Other

Other, please specify: ____________________________

Examiners: only ask this question if it was not answered at enrollment or at 3 months, if it has already been answered then skip to question 42

41. Have you used tobacco in the 12 months prior to your injury?

- No
- Yes
- Unknown

Type of tobacco: (If yes, check all that apply)

- Filtered cigarettes
- Non-filtered cigarettes
- Low tar cigarettes
- Cigars
- Pipes
- Chewing tobacco
- E-cigarettes
- Other

Other, please specify: ____________________________

42. How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2-4 times a month
- 2-3 times a week
- 4 or more times a week
- Unknown
- 1 or 2
- 3 or 4
- 5 or 6
- 7, 8, or 9
- 10 or more
- N/A have not had any alcohol since injury
- Unknown

43. How many drinks containing alcohol do you have on a typical day when you are drinking?

- 1 or 2
- 3 or 4
- 5 or 6
- 7, 8, or 9
- 10 or more
- N/A have not had any alcohol since injury
- Unknown

44. How often do you have six or more drinks on one occasion?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily
- N/A have not had any alcohol since injury
- Unknown
45. In the last month, did you use any illicit or non-prescription drugs? 'We are wanting to know about drugs like marijuana, crack or heroin; synthetic drugs like fake marijuana and bath salts, prescription drugs like pain killers or stimulants that were not prescribed to you, or chemicals you might have inhaled or 'huffed'. We also want to know if sometimes you took more than you should have of any drugs that have been prescribed to you.'

☐ No
☒ Yes
☐ Unknown

46. Ask everyone regardless of the answer above: Did you use Marijuana? (If the answer is ‘YES’ then ask, ‘Was Marijuana prescribed to you?’)

☐ No
☒ Yes (Used Marijuana that was prescribed)
☒ Yes (used Marijuana that was NOT prescribed)*
☐ Unknown

* (Note, if both prescribed and not prescribed code = not prescribed)

47. Category of illegal drugs, prescription, or over-the-counter drugs used for purposes other than those for which they are meant to be used, or in large amounts - as described above in the last month (choose all that apply)

(If category of illegal drugs is filled out then it should also be for drugs used since the injury).

a. Sedatives
☐ No
☒ Yes
☐ N/A (Not applicable (have not used any drugs including Marijuana))
☐ Unknown

b. Tranquilizers or anti-anxiety drugs
☐ No
☒ Yes
☐ N/A (Not applicable (have not used any drugs including Marijuana))
☐ Unknown
c. Painkillers
☐ No
☒ Yes
☐ N/A (Not applicable (have not used any drugs including Marijuana))
☐ Unknown
d. Stimulants
☐ No
☒ Yes
☐ N/A (Not applicable (have not used any drugs including Marijuana))
☐ Unknown
e. Marijuana, hash, THC, or grass
☐ No
☒ Yes
☐ N/A (Not applicable (have not used any drugs including Marijuana))
☐ Unknown

f. Cocaine or crack
☐ No
☒ Yes
☐ N/A (Not applicable (have not used any drugs including Marijuana))
☐ Unknown
g. Hallucinogens
☐ No
☒ Yes
☐ N/A (Not applicable (have not used any drugs including Marijuana))
☐ Unknown
h. Inhalants or solvents
☐ No
☒ Yes
☐ N/A (Not applicable (have not used any drugs including Marijuana))
☐ Unknown

i. Heroin
☐ No
☒ Yes
☐ N/A (Not applicable (have not used any drugs including Marijuana))
☐ Unknown

j. Synthetic drugs like “fake marijuana” and “bath salts”
48. In the last month, have you been in trouble at school, work, or with relationships because of drug use?

- No
- Yes
- N/A (Not applicable (have not used any drugs including Marijuana))
- Unknown

k. Any OTHER substances or medicines you have used to get high

- No
- Yes
- N/A (Not applicable (have not used any drugs including Marijuana))
- Unknown

Other, please specify

---

**Epilepsy Screening Form**

49. Have you had or has anyone ever told you that you had any of the following?

- a. Uncontrolled movements of part or all of your body such as twitching, jerking, shaking, or going limp, lasting about 5 minutes or less?

- No
- Yes
- Unknown

- b. An unexplained change in mental state or level of awareness; or an episode of “spacing out” which you could not control, lasting about 5 minutes or less?

- No
- Yes
- Unknown

- c. Any other type of repeated unusual attacks or convulsions lasting about 5 minutes or less?

- No
- Yes
- Unknown

50. Has anyone ever told you that you have seizure(s) or epilepsy?

- No
- Yes
- Unknown

If 1 or more of questions 49a, 49b, 49c or 50= "Yes" then ask questions 51 - 57. If 49a – 50 are each "No" then the interview is done.

51. Which of the following sources of information were queried? (check all that apply)

- Patient
- Caregiver
- MedicalRecord
- No
- Yes
- Unknown

52. Has the participant had seizures or epilepsy prior to the traumatic brain injury?

- No
- Yes
- Unknown

53. Has the participant been diagnosed with epilepsy, a seizure disorder, or a single seizure after the date of the traumatic brain injury diagnosis?

- No
- Yes
- Unknown

54. Did seizure(s) occur later than 7 days after the date of the traumatic brain injury?

- No
- Yes
- Unknown

55. Date of diagnosis:

56. Who gave this diagnosis?

- Neurosurgeon
- Neurologist
- Pediatric Neurologist
- Primary Care Physician
- Pediatrician
- Psychiatrist
- Psychologist
- Nurse Practitioner
- No
- Yes
- Unknown

57. Has the patient received medication for seizures or epilepsy?

- No
- Yes
- Unknown
### Interview 12Mo New

**Patient Identification Information**

**Date**  
**Start Time**  
**Stop Time**  
**Time Spent**

**Test administered in Spanish?**  
☐

**Initial Cohort**  
- CA-MRI  
- CA  
- BA  
- CA-MRI-HDF  
- CA-MRI Friend Control  
- CA Friend Control  
- CA Ortho Control  
- CA-MRI Ortho Control

**Test Completion Code**

- 1.0 Test completed in full - in person  
- 1.1 Non-standard adm - written  
- 1.2 Non-standard adm - other  
- 1.3 Test completed in full - by phone  
- 2.1 Not completed - Cognitive/neo  
- 2.2 Not completed - Non-neuro/phys  
- 2.3 Not completed - Poor effort  
- 2.4 Not completed - Language  
- 2.5 Not completed - Illness  
- 2.6 Not completed - Logistical  
- 3.1 Not attempted - Cognitive/neo  
- 3.2 Not attempted - Non-neuro/phys  
- 3.3 Not attempted - Poor effort  
- 3.4 Not attempted - Language  
- 3.5 Not attempted - Illness  
- 3.6 Not attempted - Logistical  
- 4.0 Not attempted - Examiner error  
- 5.0 Other

**Confounding Issues**

---

**Examiners:** The 12 Month patient interview is intended to target the original study injury when responding to questions. We have tried to indicate this in most questions but when in doubt or if a subject were to ask, let them know it is the study injury that is of interest for this measure.

1. **Mode of Test Administration:**
   - In-person
   - By phone
   - Subject alone
   - Subject with confirmation by significant other
   - Significant other only
   - Primarily significant other with confirmation from subject
   - Significant other:
     - Spouse
     - Parent
     - Child
     - Sibling
     - Grandparent
     - Guardian
     - Other relation
   - Reason significant other and why not done primarily with subject:

2. **Information was obtained from:**
   - Subject alone
   - Subject with confirmation by significant other
   - Significant other only
   - Primarily significant other with confirmation from subject
   - Significant other:
     - Spouse
     - Parent
     - Child
     - Sibling
     - Grandparent
     - Guardian
     - Other relation
   - Reason significant other and why not done primarily with subject:

3. **Have you sustained any other injuries since your study injury?**
   - No. Skip to question 4
   - Yes
   - Unknown. Skip to question 4

   **Date of new injury:**

   **a. Did the new injury involve a TBI?**
   - No
   - Yes
   - N/A
   - Unknown
   - with LOC - specify length in minutes
   - I was dazed but there was no LOC

   **Specify length in minutes:**

   - No
b. Did you sustain any peripheral injuries (injuries to other parts of the body)?  
☑ Yes

Specify peripheral injuries:

☐ No

Treated and released from the ED, Dr office, or other out-patient service
Admitted to hospital but no ICU*
ICU admits**

*Indicate # of days:

**Indicate # of days (hosp + ICU):


c. Did you receive treatment for the new injury?

☐ No

☑ Treated and released from the ED, Dr office, or other out-patient service
Admitted to hospital but no ICU*
ICU admit**

*Indicate # of days:

**Indicate # of days (hosp + ICU):


d. Is the new injury causing any difficulties in your daily life?

☐ No

☑ Yes

Unknown

Please specify:


4. Current Marital Status (choose one)

☐ Never married

☐ Married

☐ Domestic partnership

☐ Divorced

☐ Separated

☐ Widowed

☐ Unknown


Living situation/residence

5. Where are you living now? (choose one)

☐ Independent, lives alone (includes single parents living with minor children)

☐ Independent, lives with others (spouse, significant other)

☐ Independent, lives with others (roommate, friend)

☐ Home of parents, guardians, relatives *

☐ Home of parents, guardians, relatives, friends (due to injury/health, dependent due to health)

☐ Hospital acute care/medical ward

☐ Hospital – rehab ward

☐ Hospital – other

☐ Sub-acute/SNF

☐ Nursing home

☐ Group home/adult home

☐ Correctional

☐ Hotel

☐ Military Barracks

☐ Homeless

☐ Other

☐ Unknown

*Irrespective of injury, not due to health, includes financial reasons related to the TBI

Other, please specify:


6. If there has been a change in your living situation (pre-injury versus now), what is the reason? (choose one)

☐ Brain injury (the study injury)

☐ Other system injuries related to the study injury

☐ Both brain injury and other system injuries related to the study injury

☐ Other medical unrelated to the study injury

☐ Financial problems related to the study injury

☐ Financial problems unrelated to the study injury

☐ Other

☐ Not applicable

☐ Unknown

Other, please specify:


7. What is your current employment status? (choose one)

☐ Working now

☐ Disabled, permanently or temporarily *

☐ Only temporarily laid off, sick leave, or maternity leave **

☐ Keeping house

☐ Looking for work, unemployed ***

☐ Student

☐ Retired

☐ Other


8. Which of the following were you doing last week? * (choose one)
- Working for pay at a job or business
- Employed by a job or business, but not at work last week
- Looking for work
- Working, but not for pay, at a family owned job or business
- Not working at a job or business, and not looking for work
- Refused
- Not applicable, still in hospital
- Unknown

* This question refers to the last 7 days

9. What is the main reason you did not work last week? * (choose one)
- Taking care of house or family
- Going to school
- Retired
- On a planned vacation from work
- On family or maternity-paternity leave
- Temporarily unable to work for health reasons
- Have a job or contract, but it is the off-season
- On lay-off or unable to find work
- Disabled
- Other
- Refused
- N/A Working in last 7 days
- Still in hospital
- Unknown

* If the subject worked in the last 7 days but their normal number of hours, code them as having worked.

10. How many hours altogether did you work in the past 7 days (fill in number of hours 1 - 98)?

Or choose one below:
- N/A Not a worker pre-injury
- N/A Have not worked in the past 7 days
- N/A Still in hospital
- Unknown

11. About how many hours does your employer expect you to work in a typical 7-day week (fill in number of hours 1 - 98)?

Or choose one below:
- N/A Not a worker pre-injury
- N/A Have not worked in the past 7 days
- N/A Still in hospital
- Unknown

12. If you worked less than your usual hours last week, what is the reason?
- Health limitations resulting from the TBI (the study brain injury)
- Health limitations from other medical conditions related to the study injury
- Both health limitations from the TBI and other medical conditions related to the study injury
- Health limitations from other medical condition unrelated to the study injury
- Limitations resulting from a new injury (the injury referred to in Q#3 of this interview)
- Took time off for personal reasons unrelated to health
- Lack of available hours or shifts
- Other
- N/A, worked usual number of hours last week
- N/A, was not a worker before injury and am not a worker now
- Unknown

('usual' refers to typical hours worked pre-injury)

Specify Other

13. Current job classification category:
- None
- Craft worker
- Official/Manager
- Operative
- Professional
- Laborer/Helper
14. In the year since your injury, how many people did you personally supervise on your main job?

- None
- Under 10
- 10-99
- 100-999
- Over 1000
- Refuse to answer
- N/A
- Unknown

Click here for more information

Examiner: Questions 15a & 15b ask about entire work days missed and questions 15c & 15d ask about partial work days missed. Entire work day is defined as the number of hours the person is normally expected to work (e.g., a 4 hour work day is typically an entire work day for someone who works part-time and an 8 hour work day is an entire work day for a full time worker). Work days that are missed partially or entirely but later the missed time is made up are still counted in questions 15a-d. Note that questions 15c & d are for work days that are partially missed only (entire work days missed are just counted under 15a & 15b).

If a subject is unemployed, it will be important to find out if this is the sole reason they are not working when answering the following questions. For instance a patient who would otherwise be able to work but has no job to go to would be coded as ‘0’ in 15a and ‘20’ in 15b (provided they were working a 5 day week). See details and further examples in the data dictionary.

15. Now please think of your work experiences over the past 4 weeks (28 days). In the spaces below, provide the number of days you spent in each of the following work situations. In the past 4 weeks (28 days), how many days did you…….

a. …miss an entire work day because of problems with your physical or mental health

Number of days missed: (range 0 – 28) (or choose one below)

- N/A have not worked in the past 4 weeks (28 days)*
- Unknown

*(i.e. not in work force - retired, student, homemaker)

b. …miss an entire work day for any other reason (including vacation)?

Number of days missed: (range 0 – 28) (or choose one below)

- N/A have not worked in the past 4 weeks
- Unknown

*(i.e. not in work force - retired, student, homemaker)

c. …miss part of a work day because of problems with your physical or mental health

Number of days missed: (range 0 – 28) (or choose one below)

- N/A have not worked in the past 4 weeks (28 days)*
- Unknown

*(i.e. not in work force - retired, student, homemaker)

d. …miss part of a work day for any other reason (including vacation)?

Number of days missed: (range 0 – 28) (or choose one below)

- N/A have not worked in the past 4 weeks (28 days)*
- Unknown

*(i.e. not in work force - retired, student, homemaker)

e. …come in early, go home late, or work on your day off?

Number of days: (range 0 – 28) (or choose one below)

- N/A have not worked in the past 4 weeks (28 days)*
- Unknown

*(i.e. not in work force - retired, student, homemaker)

f. When you missed an entire work day because of problems with your physical or mental health, was this related to your head injury?

- No
- Yes
- Refused
- N/A did not miss an entire work day due to physical or mental health
g. When you missed part of an entire work day because of problems with your physical or mental health, was this related to your head injury?

16. About how many hours altogether did you work in the past 4 weeks (28 days)? (e.g., working full-time for 4 weeks = 160 hours)

17. On a scale from 0 to 10 where 0 is the worst job performance anyone could have at your job and 10 is the performance of a top worker, how would you rate the usual performance of most workers in a job similar to yours? (i.e., compared to others with similar job requirements)

18. Using the same 0 to 10 scale, how would you rate your overall performance during the past 4 weeks (28 days)?

19. In the last two months, has your employer offered you any of the following in response to any health limitations related to your injury? (Check No, Yes, Unk (unknown) or N/A (not applicable) for each)

   Examiner: also code 'yes' here if the person took advantage of an existing benefit

   1. Sick leave
   2. Part-time or reduced hours
   3. Modified schedule
   4. Transfer to a different job with different tasks
   5. Equipment/assistive technology to help perform the job
   6. Job coaching/mentor to be able to do job

20. Did you attend school in the last week? (choose one)
21. What is the main reason you did not attend school in the past week? (choose one)
- Brain injury (the study injury)
- Other system injuries related to the study injury
- Both brain injury and other system injuries related to the study injury
- Other medical problem unrelated to study injury
- Financial problem related to the study injury
- Financial problem unrelated to the study injury
- Planned vacation/scheduled time off *
- Other
- N/A - attended school in the last week
- N/A - not a student pre-injury and no plans to attend
- Unknown
- Limitations as a result of the new injury as documented in Q#3
* Examiners: if the person could not attend school for other reasons in addition to it being during a vacation period choose the other reason
Other, please specify:

Questions 22 – 24 are asked if they were not asked before, otherwise skip these questions and go to question 25

Follow-up Care
22. Did you receive education materials from the hospital where you were treated for your injury? Choose one:
- No
- Yes
- Unknown

23. Were you given contact information for where to follow up with symptoms from your injury? (choose one)
- No
- Yes
- Unknown

24. Did anyone from the hospital call you to follow up with you about your injury? (choose one)
- No
- Yes
- Unknown

25. Have you seen any healthcare provider since your last study visit for your traumatic brain injury?
- No
- Yes
- Unknown

Type of clinician care:
(If yes, check all that apply)
- General practitioner (primary care)
- TBI/Concussion Clinic
- Neurologist
- Physiatrist
- Chiropractor
- Psychiatrist
- Psychologist, psychological services
- Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.)
- Other
Other, please specify

Did it help?
- No
- Yes
- Unknown

26. Have you seen any healthcare provider since your last study visit for injuries to the body other than the brain (e.g. fractured limbs, eye injuries, etc.)?
- No
- Yes
<table>
<thead>
<tr>
<th>Type of healthcare provider: (If yes, check all that apply)</th>
<th>Did it help?</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner (primary care)</td>
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<tr>
<td></td>
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</tr>
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<td>Cardiologist</td>
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<td>Orthopedics</td>
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<td>Oral and maxillofacial Surgery</td>
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<td>Plastic Surgery</td>
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<td>Other, please specify:</td>
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<tr>
<td></td>
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</tbody>
</table>

27. Did you receive any inpatient or outpatient rehabilitation treatment to address problems related to your brain injury within the last 6 months? (choose one)
- No, skip to Question 30
- Yes
- Unknown, skip to Question 30

28. Were you treated as an **inpatient** to address problems related to your brain injury within the last 6 months?
- No, skip to Question 29
- Yes

How long did you receive treatment?
- < 2 weeks
- 2-4 weeks
- 5-8 weeks
- 9-12 weeks
- > 12 weeks
- Active inpatient rehab ongoing
- Unknown

Did you receive inpatient treatment at any of the following facilities:
- Acute Care Hospital
- Long-Term Acute Care Hospital (LTACH)
- Inpatient Rehabilitation Facility (IRF)
- Skilled Nursing Facility
- Other

Other, please specify:

What type of therapy services did you receive?
- Physical therapy
- Occupational therapy
- Speech therapy
- Therapeutic recreation
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<tr>
<th>Service Type</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
<th>Option 5</th>
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<tbody>
<tr>
<td>Cognitive remediation</td>
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<td>Psychological services</td>
<td>No</td>
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<td>Nursing services</td>
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<td>Peer mentoring</td>
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<td>Social work/Case management</td>
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<td>Independent living training</td>
<td>No</td>
<td>Yes</td>
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<td>Other</td>
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<td>Other, please specify:</td>
<td></td>
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</tbody>
</table>

29. Were you treated as an **outpatient** for problems related to your brain injury within the last 6 months?  
- No  
- Yes  

How long did you receive treatment?  
- < 2 weeks  
- 2-4 weeks  
- 5-8 weeks  
- 9-12 weeks  
- > 12 weeks  
- Active outpatient rehab ongoing  
- Unknown  

Did you receive outpatient treatment at any of the following facilities?  
- Residential Living Facility/Independent Living Center/Group Home  
  - No  
  - Yes  
  - Unknown  
- Outpatient General Medical Clinic  
  - No  
  - Yes  
  - Unknown  
- Outpatient Rehabilitation Clinic  
  - No  
  - Yes  
  - Unknown  
- Home (i.e., therapist comes to person's home)  
  - No  
  - Yes  
  - Unknown  
- Other  
  - No  
  - Yes  
  - Unknown  
  - Other, please specify:  

What type of outpatient therapy services did you receive? (Check all that apply)  
- Physical therapy  
  - No  
  - Yes  
  - Unknown  
- Occupational therapy  
  - No  
  - Yes  
  - Unknown  
- Speech therapy  
  - No  
  - Yes  
  - Unknown  
- Therapeutic recreation  
  - No  
  - Yes  
  - Unknown  
- Cognitive remediation  
  - No  
  - Yes  
  - Unknown  
- Psychological services  
  - No  
  - Yes
| Nursing services | Unknown | No | Yes | Unknown |
| Peer mentoring | Unknown | No | Yes | Unknown |
| Social work/Case management | Unknown | No | Yes | Unknown |
| Independent living training | Unknown | No | Yes | Unknown |
| Other | Unknown | No | Yes | Unknown |

**Examiners – only ask this question if it wasn’t answered at an earlier interview, if it was answered before go to question 31**

30. If you did not receive any rehabilitation treatment to address problems related to your brain injury following your ED/visit/discharge from the hospital, please select your:

**Follow-up care interest level:**
- Interested in follow-up care
- Not interested in follow-up care
- Unknown

**Other reason:** Other, please specify:

Interested in follow-up care, please check any/all of the reasons that apply:
- but no/insufficient insurance coverage
- but insurance coverage was denied
- but could not arrange transportation
- but worried about the physical (e.g. increased pain), emotional (e.g. depression, anxiety) or personal (e.g. too much time, delay in going back to work/school) consequences it might cause
- but worried about the burden it would place on others close to me (e.g. cost, time, additional demands)
- but treatment services have not yet been arranged
- but not give any information/referral
- Other

Interested in follow-up care Other, please specify:

Not interested in follow-up care, please check any/all of the reasons that apply:
- because I did not think I needed it (e.g., Dr. said I didn’t need it and/or didn’t need a referral for that reason)
- because I believe I can manage the problems caused by my injury on my own
- because I was dissatisfied with the treatment I received at the ED/hospital

31. Did you receive any inpatient or outpatient rehabilitation for any injuries to the body other than the brain (e.g., fractured limbs, eye injuries, etc.) within the last 6 months?
- No, skip to Question 32
- Yes
- Unknown, skip to Question 32

**If so, how long?**
- < 2 weeks
- 2-4 weeks
- 5-8 weeks
- 9-12 weeks
- > 12 weeks
- Active rehab ongoing
- Unknown

**Did it help?**

**Type of therapy:**
(check all that apply)

**Inpatient Rehabilitation**
- Physical Therapy
  - No
  - Yes
  - Unknown

- Occupational Therapy
  - No
  - Yes
  - Unknown

- Other
32. Overall, how satisfied are you with the availability of support from people close to you over the last 6 months?

- Not at all
- Slightly
- Moderately
- Quite
- Very
- Unknown

33. Overall, how satisfied are you with the health care services you received after your hospital discharge (including rehabilitation)?

- Not at all
- Slightly
- Moderately
- Quite
- Very
- N/A received no health service after hospital
- N/A still in hospital
- Unknown

34. Do you think you needed more health care services than you have received so far?

- No
- Yes
- Unknown

35. Overall, how satisfied are you with the support you have received from your employer since your injury?

- Not at all
- Slightly
- Moderately
- Quite
- Very
- N/A no contact with employer
- N/A self-employed or not working
- Unknown

Hearing/Speech Questions

36. In the past week, has your hearing been worse than prior to your injury in either ear?

- No
- Yes, worse in the left ear
- Yes, worse in the right ear
- Yes, worse in both ears
- Unknown

37. In the past week, have you been bothered by new or worse than pre-injury ringing, roaring, buzzing or other sounds in your ears or head that lasts for 5 minutes or more?

- No
- Yes
- Unknown

38. In the past week, have you had a problem with dizziness, lightheadedness, feeling as if you are going to pass out or faint, unsteadiness or imbalance?

- No
- Yes
- Unknown

39. In the past week, has your ability to taste or smell changed from pre-injury?

- No
- Yes
- Unknown

40. In the past week, have you had any problems with the following?
   a. Voice problem
   - No
   - Yes
   - Unknown
   b. Swallowing problem
   - No
   - Yes
   - Unknown
   c. Speech problem
   - No
   - Yes
   - Unknown
   d. Language problem
   - No
   - Yes
   - Unknown

Caregiver Time
41. We need to understand difficulties people may have with various activities because of a health or physical problem. Please tell me whether you require help doing everyday activities such as the following: getting across a room, dressing, bathing, eating, getting (in/out of) bed, using the toilet, preparing meals, shopping for groceries, making telephone calls, taking your medications, managing your money.  
42. Who most often helps you with these tasks?

43. Do you currently use tobacco?  
- No (go on to #44)  
- Yes  
- Unknown  

Type of tobacco:  
(If yes, check all that apply)  
- Filtered cigarettes  
- Non-filtered cigarettes  
- Low tar cigarettes  
- Cigars  
- Pipes  
- Chewing tobacco  
- E-cigarettes  
- Other  
Other, please specify:  

Examiners: only ask this question if it was not answered at enrollment or prior follow-up, if it has already been answered then skip to question 45

44. Have you used tobacco in the 12 months prior to your injury?  
- No (go on to #45)  
- Yes  
- Unknown  

Type of tobacco:  
(If yes, check all that apply)  
- Filtered cigarettes  
- Non-filtered cigarettes  
- Low tar cigarettes  
- Cigars  
- Pipes  
- Chewing tobacco  
- E-cigarettes  
- Other  
Other, please specify:  

45. How often do you have a drink containing alcohol?  
- Never  
- Monthly or less  
- 2-4 times a month  
- 2-3 times a week  
- 4 or more times a week  
- Unknown  
- 1 or 2  
- 3 or 4  
- 5 or 6  
- 7, 8, or 9  
- 10 or more  
- N/A have not had any alcohol since injury  
- Unknown  

46. How many drinks containing alcohol do you have on a typical day when you are drinking?  
- 1 or 2  
- 3 or 4  
- 5 or 6  
- 7, 8, or 9  
- 10 or more  
- N/A have not had any alcohol since injury  
- Unknown  

47. How often do you have six or more drinks on one occasion?  
- Never  
- Less than monthly  
- Monthly  
- Weekly  
- Daily or almost daily  
- N/A have not had any alcohol since injury  
- Unknown
48. In the last month, did you use any illicit or non-prescription drugs? 'We are wanting to know about drugs like marijuana, crack or heroin; synthetic drugs like fake marijuana and bath salts, prescription drugs like pain killers or stimulants that were not prescribed to you, or chemicals you might have inhaled or “huffed”. We also want to know if sometimes you took more than you should have of any drugs that have been prescribed to you.'

<table>
<thead>
<tr>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
</tbody>
</table>

49. Ask everyone regardless of the answer above: Did you use Marijuana? (If the answer is “YES” then ask, “Was Marijuana prescribed to you?”)

<table>
<thead>
<tr>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes (Used Marijuana that was prescribed)</td>
</tr>
<tr>
<td>Yes (used Marijuana that was NOT prescribed)*</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
</tbody>
</table>

* (Note, if both prescribed Marijuana and Marijuana that was not prescribed code = NOT prescribed)

50. Category of illegal drugs, prescription, or over-the-counter drugs used for purposes other than those for which they are meant to be used, or in large amounts - as described above in the last month (choose all that apply)

(If category of illegal drugs is filled out then it should also be for drugs used since the injury).

- **a. Sedatives**
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- **b. Tranquilizers or anti-anxiety drugs**
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- **c. Painkillers**
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- **d. Stimulants**
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- **e. Marijuana, hash, THC, or grass**
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- **f. Cocaine or crack**
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- **g. Hallucinogens**
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- **h. Inhalants or solvents**
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- **i. Heroin**
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- **j. Synthetic drugs like “fake marijuana” and “bath salts”**
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown
- **k. Any OTHER substances or medicines you have used to get high**
  - No
  - Yes
  - N/A (Not applicable (have not used any drugs including Marijuana))
  - Unknown

Other, please specify
51. In the last month, have you been in trouble at school, work, or with relationships because of drug use?
- No
- Yes
- N/A (have not used any drugs including Marijuana)
- Unknown

52. Since the injury have you received any outpatient help (counseling, psychotherapy) from a psychiatrist, psychologist, social worker, or counselor for problems such as depression, anxiety, anger management, or any other difficulty?
- No
- Yes
- Unknown

53. Since the injury, have you been hospitalized for emotional or psychiatric problems?
- No
- Yes
- Unknown

54. Since the injury have you taken any psychiatric medications regularly? These are medicines for mood or anxiety or mental health problems.
- No
- Yes
- Unknown

### Epilepsy Screening Form

55. Which of the following sources of information were queried? (check all that apply)
- Patient
- Caregiver
- MedicalRecord

Have you had or has anyone ever told you that you had any of the following?

- Uncontrolled movements of part or all of your body such as twitching, jerking, shaking, or going limp, lasting about 5 minutes or less?
- An unexplained change in mental state or level of awareness; or an episode of "spacing out" which you could not control, lasting about 5 minutes or less?
- Any other type of repeated unusual attacks or convulsions lasting about 5 minutes or less?

56. Has anyone ever told you that you have seizure(s) or epilepsy?
- No
- Yes
- Unknown

If 1 or more of questions 55a, 55b, 55c or 56= "Yes" then ask questions 57 - 62. If 55a – 56 are each "No" then skip Question 57-62 and go to question 63.

57. Did the most recent seizure(s) occur later than 7 days after the date of the traumatic brain injury?
- No
- Yes
- Unknown

58. Has the participant had seizures or epilepsy prior to the traumatic brain injury?
- No
- Yes
- Unknown

59. Has the participant been diagnosed with epilepsy, a seizure disorder, or a single seizure after the date of the traumatic brain injury diagnosis?
- No
- Yes
- Unknown

60. Date of diagnosis:

61. Who gave this diagnosis?
- Neurosurgeon
- Neurologist
- Pediatric Neurologist
- Primary Care Physician
- Pediatrician
- Psychiatrist
- Psychologist
- Nurse Practitioner
- No
- Yes
- Unknown

62. Have you received medication for seizures or epilepsy?
- No
- Yes
- Unknown

- Pre injury only
- Post injury, but not currently
- Currently
63. Are you or were you involved in litigation due to your injury?

☐ No
☐ Yes, suing another party or insurance company
☐ Yes, defendant in lawsuit
☐ Both suing and defendant
☐ Unknown

64. If you are not presently involved in litigation, are you planning on being involved?

☐ No
☐ Yes, planning on suing another party or insurance company
☐ Yes, will probably be a defendant
☐ Yes, both suing and a defendant
☐ Unsure
☐ Other
☐ Unknown
Other, please specify: ____________________________

65. If involved, have you received any settlement?

☐ No
☐ Yes
☐ N/A not involved
☐ Unknown

66. Is the patient covered by any of the following types of health insurance?

☐ Self-pay (uninsured)

☐ Insurance through a current or former employer (of this person or another family member)

☐ Insurance purchased directly from an insurance company or on the health insurance exchange (this person or family member)

☐ Medicare, for people 65 and older, or people with certain disabilities

☐ Medicaid, Medical Assistance, ‘the State’ or any kind of government-assistance plan for those with low incomes or a disability

☐ Medicaid Pending

☐ TRICARE, VA or other military health care

☐ Any other type of health insurance or health coverage plan

Income and Assets
The next questions are about things like your income, wealth, and where you live. We are asking these questions to better understand how income and wealth may help or hinder being able to receive health care services. We understand that these are sensitive questions, and like the rest of the survey, your answers to these questions will be kept confidential. You are also free not to answer any question you find objectionable.

67. A household includes all the persons who occupy a house, an apartment, a mobile home, a group of rooms, or a single room. The occupants may be a single family, one person living alone, two or more families living together, or any other group of related or unrelated persons who share living arrangements. How many people live in your household?

☐ Unknown

68. During the last year, how much money did you receive from wages or salary, tips, commissions, or bonuses, or your own business or practice, before taxes and other deductions?

☐ None
☐ Less than $10,000
☐ $10,000 to $14,999
☐ $15,000 to $24,999
☐ $25,000 to $34,999
☐ $35,000 to $49,999
☐ $50,000 to $74,999
☐ $75,000 to $99,999
☐ $100,000 to $149,999
☐ $150,000 to $199,999

☐ Unknown
69. I would like to now ask you some questions about your total household income. Income can come from a number of sources: jobs, net income from business, farm or rent, pensions, dividends, interest, social security payments and any other money income. What was your total household income in the last year (before taxes and other deductions)?

- None
- Less than $10,000
- $10,000 to $14,999
- $15,000 to $24,999
- $25,000 to $34,999
- $35,000 to $49,999
- $50,000 to $74,999
- $75,000 to $99,999
- $100,000 to $149,999
- $150,000 to $199,999
- $200,000 to $299,999
- $300,000 to $499,999
- $500,000 to $999,999
- $1,000,000 or more
- Refused to answer
- Unknown

70. Do you own your home or apartment, pay rent, stay with family or friends, or something else?

- Own
- Pay rent
- Staying with family or friends
- Homeless
- Unknown
- Other

71. What is the total value of that property in U.S. dollars? (Answer only if the homeowner)

- Less than $50,000
- $50,000 to $99,999
- $100,000 to $149,999
- $150,000 to $199,999
- $200,000 to $299,999
- $300,000 to $499,999
- $500,000 to $999,999
- $1,000,000 or more
- Refused to answer
- N/A not a home owner
- Unknown
- Negative or zero
- $1 to $4,999
- $5,000 to $9,999
- $10,000 to $24,999
- $25,000 to $49,999
- $50,000 to $99,999
- $100,000 to $249,999
- $250,000 to $499,999
- $500,000 and over

72. What is your household net worth? Net worth is the value of what every member of your household owns (such as cars, real estate, savings, retirement accounts) minus what every member of your household owes. Do not include the value of life insurance, home furnishings or jewelry. (Examiners: This question can be difficult for many people to answer. Encourage them to take their best estimated guess. May first try getting them to narrow the response options to a couple and then select what seems to be the best.)

- Negative or zero
- $1 to $4,999
- $5,000 to $9,999
- $10,000 to $24,999
- $25,000 to $49,999
- $50,000 to $99,999
- $100,000 to $249,999
- $250,000 to $499,999
- $500,000 and over
- Refused to answer
- N/A not a home owner
- Unknown

https://studydata.net/qgen/YFormPrint.php?FormName=Interview12Mo
| 81 | Refused to answer | Unknown |
**CAP 2Wk**

**Patient Identification Information**

**Date**

**Start Time**

**Stop Time**

**Time Spent**

**Test Completion Code**

- 1.0 Test completed in full - in person
- 1.1 Non-standard adm - written
- 1.2 Non-standard adm - other
- 2.1 Not completed - Cognitive/neuro
- 2.2 Not completed - Non-neuro/phys
- 2.3 Not completed - Poor effort
- 2.4 Not completed - Language
- 2.5 Not completed - Illness
- 2.6 Not completed - Logistical
- 3.1 Not attempted - Cognitive/neuro
- 3.2 Not attempted - Non-neuro/phys
- 3.3 Not attempted - Poor effort
- 3.4 Not attempted - Language
- 3.5 Not attempted - Illness
- 3.6 Not attempted - Logistical
- 4.0 Not attempted - Examiner error
- 5.0 Other

**Completion Code Other**

**Confounding Issues**

---

**TOTART Attention Subtest (TAS)**

A. Count forward from 1 to 20

- Correct
- Incorrect

B. Count backward from 20 to 1

- 4-Correct
- 0-Incorrect

C. Recite the months of the year

- 2-Correct
- 0-Incorrect

D. Recite the months of the year backwards

- 6-Correct
- 0-Incorrect

---

**CTD Vigilance (V1)**

Read the letter list at the rate of one letter per 2 seconds. On the form used, put a slash mark through each letter H that the patient responds to (raises hand or says yes). Circle any omissions (no response to the letter H). Count up the number of correct responses (hits) and the number of incorrect responses (omissions).

<table>
<thead>
<tr>
<th>Number of Hits (correct targets identified)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Omissions (incorrect targets identified)</td>
<td></td>
</tr>
</tbody>
</table>

**CTD Vigilance Score** = Hits (correct targets identified) X 2 – Commissions

- 36
- 30-35
- <30

---

**CTD Comprehension**

Number of correct answers

- 4
- 3
- 0, 1, or 2

---

**CTD Visual Picture Memory Test**

Number of correct answers

- 10
- 9
- 7 or 8
- 0-6
| Total Cognitive Impairment Score | 83 |
# CRS-R 2Wk

## Patient Identification Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Time Spent</th>
</tr>
</thead>
</table>

## Test Completion Code

- **1.0** Test completed in full - in person
- **1.1** Non-standard adm - written
- **1.2** Non-standard adm - other
- **2.1** Not completed - Cognitive/neuro
- **2.2** Not completed - Non-neuro/phys
- **2.3** Not completed - Poor effort
- **2.4** Not completed - Language
- **2.5** Not completed - Illness
- **2.6** Not completed - Logistical
- **3.1** Not attempted - Cognitive/neuro
- **3.2** Not attempted - Non-neuro/phys
- **3.3** Not attempted - Poor effort
- **3.4** Not attempted - Language
- **3.5** Not attempted - Illness
- **3.6** Not attempted - Logistical
- **4.0** Not attempted - Examiner error
- **5.0** Other

**Test Completion Codes**

**Completion Code Other**

**Confounding Issues**

### AUDITORY FUNCTION SCALE
- **4** - Consistent Movement to Command *
- **3** - Reproducible Movement to Command *
- **2** - Localization to Sound
- **1** - Auditory Startle
- **0** - None

### VISUAL FUNCTION SCALE
- **5** - Object Recognition *
- **4** - Object Localization, Reaching *
- **3** - Visual Pursuit *
- **2** - Fixation *
- **1** - Visual Startle
- **0** - None

### MOTOR FUNCTION SCALE
- **6** - Functional Object Use†
- **5** - Automatic Motor Response *
- **4** - Object Manipulation *
- **3** - Localization to Noxious Stimulation *
- **2** - Flexion Withdrawal
- **1** - Abnormal Posturing
- **0** - None/Flaccid

### OROMOTOR/VERBAL FUNCTION SCALE
<table>
<thead>
<tr>
<th>Scale</th>
<th>Description</th>
<th>Score</th>
</tr>
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<tbody>
<tr>
<td><strong>COMMUNICATION SCALE</strong></td>
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<tr>
<td>3 - Intelligible Verbalization *</td>
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<tr>
<td>2 - Vocalization/Oral Movement</td>
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<tr>
<td>1 - Oral Reflexive Movement</td>
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<tr>
<td>0 - None</td>
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<tr>
<td><strong>AROUSAL SCALE</strong></td>
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<tr>
<td>3 - Attention</td>
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<tr>
<td>2 - Eye Opening w/o Stimulation</td>
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<td></td>
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<tr>
<td>1 - Eye Opening with Stimulation</td>
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<td>0 - Unarousable</td>
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<tr>
<td><strong>TOTAL SCORE</strong></td>
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# TMT WAIS RAVLT NIH 2Wk

## Patient Identification Information

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<td></td>
<td>4.0 Not attempted - Examiner error</td>
</tr>
<tr>
<td></td>
<td>5.0 Other</td>
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</table>

## Confounding Issues

<table>
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<tbody>
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<td>Date</td>
<td>Start Time</td>
</tr>
<tr>
<td>Stop Time</td>
<td>Time Spent</td>
</tr>
</tbody>
</table>

## Hand Used

- [ ] Dominant
- [ ] Non-Dominant

## Trail Making Part A  Trail Making Part B

<table>
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## WAIS IV

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</tr>
<tr>
<td>1.2 Non-standard adm - other</td>
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<td>3.3 Not attempted - Poor effort</td>
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### Symbol Search Subset
- Total correct (raw): 
- Total incorrect (raw): 
- Total Raw Score:

### Coding Subset
- Total correct (raw): 

### Test Completion Codes
- WAIS Completion Code Other 

### Confounding Issues

### RAVLT
- RAVLT Completion Code
  - 1.0 Test completed in full
  - 1.1 Non-standard adm - written
  - 1.2 Non-standard adm - other
  - 2.1 Not completed - Cognitive/neuro
  - 2.2 Not completed - Non-neuro/phys
  - 2.3 Not completed - Poor effort
  - 2.4 Not completed - Language
  - 2.5 Not completed - Illness
  - 2.6 Not completed - Logistical
  - 3.1 Not attempted - Cognitive/neuro
  - 3.2 Not attempted - Non-neuro/phys
  - 3.3 Not attempted - Poor effort
  - 3.4 Not attempted - Language
  - 3.5 Not attempted - Illness
  - 3.6 Not attempted - Logistical
  - 4.0 Not attempted - Examiner error
  - 5.0 Other

**Test Completion Codes**

<table>
<thead>
<tr>
<th>Test Completion Code</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Test completed in full</td>
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</tr>
<tr>
<td>1.1 Non-standard adm - written</td>
<td></td>
</tr>
<tr>
<td>1.2 Non-standard adm - other</td>
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<td>2.1 Not completed - Cognitive/neuro</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>4.0 Not attempted - Examiner error</td>
<td></td>
</tr>
<tr>
<td>5.0 Other</td>
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</table>

### Confounding Issues

### Time Spent

<table>
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<tr>
<th>Date</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Time Spent</th>
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### RAVLT

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<th>Total correct (raw)</th>
<th>Total incorrect (raw)</th>
<th>Total Raw Score</th>
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<table>
<thead>
<tr>
<th>Coding Subset</th>
<th>Total correct (raw)</th>
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<table>
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<td></td>
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<td></td>
<td>5.0 Other</td>
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<th>Stop Time</th>
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</thead>
<tbody>
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</table>
# of Correct Responses

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<thead>
<tr>
<th>Principal List Recall Trial 1</th>
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<tbody>
<tr>
<td>Principal List Recall Trial 2</td>
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<tr>
<td>Principal List Recall Trial 3</td>
<td></td>
</tr>
<tr>
<td>Principal List Recall Trial 4</td>
<td></td>
</tr>
<tr>
<td>Principal List Recall Trial 5</td>
<td></td>
</tr>
<tr>
<td>Interference List Recall Trial 1</td>
<td></td>
</tr>
<tr>
<td>Principal List Recall Trial 6</td>
<td></td>
</tr>
<tr>
<td>20 Minute Delay Principal List Recall Trial 7</td>
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</tr>
</tbody>
</table>

NIH Toolbox Cognitive Battery

<table>
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<tr>
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</thead>
<tbody>
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<tr>
<td>1.2 Non-standard adm - other</td>
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</tr>
<tr>
<td>4.0 Not attempted - Examiner error</td>
</tr>
<tr>
<td>5.0 Other</td>
</tr>
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</table>

Test Completion Codes

NIH Completion Code Other

NIH Confounding Issues

Date  Start Time  Stop Time  Time Spent
# BTACT 6Mo

**Patient Identification Information**

<table>
<thead>
<tr>
<th>Date</th>
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<th>Stop Time</th>
<th>Time Spent</th>
</tr>
</thead>
</table>

**Test Completion Code**

- 1.0 Test completed in full - in person
- 1.1 Non-standard adm - written
- 1.2 Non-standard adm - other
- 1.3 Test completed in full - by phone
- 2.1 Not completed - Cognitive/neuro
- 2.2 Not completed - Non-neuro/phys
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- 3.5 Not attempted - Illness
- 3.6 Not attempted - Logistical
- 4.0 Not attempted - Examiner error
- 5.0 Other

Completion Code Other

**Confounding Issues**

---

**Word List Recall - Immediate & Delayed**

- Total number of Trial 1 correct responses
- Total number of 20 minute delay recall correct responses

**Digits Backward**

- Score

**Category Fluency**

- Total number unique
- Total repetitions
- Total intrusions

**Stop and Go Task Accuracy**

- Normal baseline score
- Reverse baseline score
- Experimental Score

**Number Series**

- Total number of items correct

**30 Seconds and Counting Task**

- Last number reached
- Total number of errors
| Total number of digits produced | 100 - (number reached + number errors) | 90 |
After a head injury or accident, some people experience symptoms that can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below, please select the number that most closely represents your answer.

0 = not experienced at all
1 = no more of a problem
2 = a mild problem
3 = a moderate problem
4 = a severe problem

Compared with **before** the accident, do you now (i.e., over the last 7 days) suffer from:

### Headaches
- 0 - Not experienced at all
- 1 - No more of a problem
- 2 - A mild problem
- 3 - A moderate problem
- 4 - A severe problem

### Feelings of dizziness
- 0 - Not experienced at all
- 1 - No more of a problem
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea and/or vomiting</td>
<td>0-Not experienced at all</td>
</tr>
<tr>
<td></td>
<td>1- No more of a problem</td>
</tr>
<tr>
<td></td>
<td>2- A mild problem</td>
</tr>
<tr>
<td></td>
<td>3- A moderate problem</td>
</tr>
<tr>
<td></td>
<td>4- A severe problem</td>
</tr>
<tr>
<td>Noise sensitivity (easily upset by loud noise)</td>
<td>0-Not experienced at all</td>
</tr>
<tr>
<td></td>
<td>1- No more of a problem</td>
</tr>
<tr>
<td></td>
<td>2- A mild problem</td>
</tr>
<tr>
<td></td>
<td>3- A moderate problem</td>
</tr>
<tr>
<td></td>
<td>4- A severe problem</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>0-Not experienced at all</td>
</tr>
<tr>
<td></td>
<td>1- No more of a problem</td>
</tr>
<tr>
<td></td>
<td>2- A mild problem</td>
</tr>
<tr>
<td></td>
<td>3- A moderate problem</td>
</tr>
<tr>
<td></td>
<td>4- A severe problem</td>
</tr>
<tr>
<td>Fatigue, tiring more easily</td>
<td>0-Not experienced at all</td>
</tr>
<tr>
<td></td>
<td>1- No more of a problem</td>
</tr>
<tr>
<td></td>
<td>2- A mild problem</td>
</tr>
<tr>
<td></td>
<td>3- A moderate problem</td>
</tr>
<tr>
<td></td>
<td>4- A severe problem</td>
</tr>
<tr>
<td>Being irritable, easily angered</td>
<td>0-Not experienced at all</td>
</tr>
<tr>
<td></td>
<td>1- No more of a problem</td>
</tr>
<tr>
<td></td>
<td>2- A mild problem</td>
</tr>
<tr>
<td></td>
<td>3- A moderate problem</td>
</tr>
<tr>
<td></td>
<td>4- A severe problem</td>
</tr>
<tr>
<td>Feeling depressed or tearful</td>
<td>0-Not experienced at all</td>
</tr>
<tr>
<td></td>
<td>1- No more of a problem</td>
</tr>
<tr>
<td></td>
<td>2- A mild problem</td>
</tr>
<tr>
<td></td>
<td>3- A moderate problem</td>
</tr>
<tr>
<td></td>
<td>4- A severe problem</td>
</tr>
<tr>
<td>Feeling frustrated or impatient</td>
<td>0-Not experienced at all</td>
</tr>
<tr>
<td></td>
<td>1- No more of a problem</td>
</tr>
<tr>
<td></td>
<td>2- A mild problem</td>
</tr>
<tr>
<td></td>
<td>3- A moderate problem</td>
</tr>
<tr>
<td></td>
<td>4- A severe problem</td>
</tr>
<tr>
<td>Forgetfulness, poor memory</td>
<td>0-Not experienced at all</td>
</tr>
<tr>
<td></td>
<td>1- No more of a problem</td>
</tr>
<tr>
<td></td>
<td>2- A mild problem</td>
</tr>
<tr>
<td></td>
<td>3- A moderate problem</td>
</tr>
<tr>
<td></td>
<td>4- A severe problem</td>
</tr>
<tr>
<td>Poor concentration</td>
<td>0-Not experienced at all</td>
</tr>
<tr>
<td></td>
<td>1- No more of a problem</td>
</tr>
<tr>
<td></td>
<td>2- A mild problem</td>
</tr>
<tr>
<td></td>
<td>3- A moderate problem</td>
</tr>
<tr>
<td></td>
<td>4- A severe problem</td>
</tr>
<tr>
<td>Taking longer to think</td>
<td>0-Not experienced at all</td>
</tr>
<tr>
<td></td>
<td>1- No more of a problem</td>
</tr>
<tr>
<td></td>
<td>2- A mild problem</td>
</tr>
<tr>
<td></td>
<td>3- A moderate problem</td>
</tr>
<tr>
<td></td>
<td>4- A severe problem</td>
</tr>
<tr>
<td>Blurred vision</td>
<td>0-Not experienced at all</td>
</tr>
<tr>
<td></td>
<td>1- No more of a problem</td>
</tr>
<tr>
<td></td>
<td>2- A mild problem</td>
</tr>
<tr>
<td></td>
<td>3- A moderate problem</td>
</tr>
<tr>
<td></td>
<td>4- A severe problem</td>
</tr>
<tr>
<td>Condition</td>
<td>Score</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Light sensitivity (easily upset</td>
<td></td>
</tr>
<tr>
<td>by bright light)</td>
<td></td>
</tr>
<tr>
<td>0-Not experienced at all</td>
<td></td>
</tr>
<tr>
<td>1- No more of a problem</td>
<td></td>
</tr>
<tr>
<td>2- A mild problem</td>
<td></td>
</tr>
<tr>
<td>3- A moderate problem</td>
<td></td>
</tr>
<tr>
<td>4- A severe problem</td>
<td></td>
</tr>
<tr>
<td>Double vision</td>
<td></td>
</tr>
<tr>
<td>0-Not experienced at all</td>
<td></td>
</tr>
<tr>
<td>1- No more of a problem</td>
<td></td>
</tr>
<tr>
<td>2- A mild problem</td>
<td></td>
</tr>
<tr>
<td>3- A moderate problem</td>
<td></td>
</tr>
<tr>
<td>4- A severe problem</td>
<td></td>
</tr>
<tr>
<td>Restlessness</td>
<td></td>
</tr>
<tr>
<td>0-Not experienced at all</td>
<td></td>
</tr>
<tr>
<td>1- No more of a problem</td>
<td></td>
</tr>
<tr>
<td>2- A mild problem</td>
<td></td>
</tr>
<tr>
<td>3- A moderate problem</td>
<td></td>
</tr>
<tr>
<td>4- A severe problem</td>
<td></td>
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</table>

**Scoring (Coming soon)**

- RPQ-3
- RPQ-13
# PROMIS-PAIN 2Wk

**Patient Identification Information**

<table>
<thead>
<tr>
<th>Date</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Time Spent</th>
<th>Test Completion Code</th>
</tr>
</thead>
</table>

**Test Completion Codes**

**Completion Code Other**

**Confounding Issues**

**In the past 7 days...**

**How intense was your pain at its worst?**

- [ ] 1 - Had no pain
- [ ] 2 - Mild
- [ ] 3 - Moderate
- [ ] 4 - Severe
- [ ] 5 - Very severe

**How intense was your average pain?**

- [ ] 1 - Had no pain
- [ ] 2 - Mild
- [ ] 3 - Moderate
- [ ] 4 - Severe
- [ ] 5 - Very severe

**What is your level of pain right now?**

- [ ] 1 - Had no pain
- [ ] 2 - Mild
- [ ] 3 - Moderate
- [ ] 4 - Severe
- [ ] 5 - Very severe

**In the past 7 days...**

**How much did pain interfere with your day to day activities?**

- [ ] 1 - Not at all
- [ ] 2 - A little bit
- [ ] 3 - Somewhat
- [ ] 4 - Quite a bit
- [ ] 5 - Very much

**How much did pain interfere with work around the home?**

- [ ] 1 - Not at all
- [ ] 2 - A little bit
- [ ] 3 - Somewhat
- [ ] 4 - Quite a bit
- [ ] 5 - Very much

**How much did pain interfere with your ability to participate in social activities?**

- [ ] 1 - Not at all
- [ ] 2 - A little bit
- [ ] 3 - Somewhat
- [ ] 4 - Quite a bit
- [ ] 5 - Very much

**How much did pain interfere with your household chores?**

- [ ] 1 - Not at all
- [ ] 2 - A little bit
- [ ] 3 - Somewhat
- [ ] 4 - Quite a bit
- [ ] 5 - Very much
The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the ‘Guidelines for Scoring/Interpretation’ below to see where your sleep difficulty fits. For each question, please SELECT the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

<table>
<thead>
<tr>
<th>Question</th>
<th>Scoring Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Difficulty falling asleep</td>
<td>0 None, 1 Mild, 2 Moderate, 3 Severe, 4 Very Severe</td>
</tr>
<tr>
<td>2. Difficulty staying asleep</td>
<td>0 None, 1 Mild, 2 Moderate, 3 Severe, 4 Very Severe</td>
</tr>
<tr>
<td>3. Problems waking up too early</td>
<td>0 None, 1 Mild</td>
</tr>
</tbody>
</table>
4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

- 0 Very Satisfied
- 1 Satisfied
- 2 Moderately Satisfied
- 3 Dissatisfied
- 4 Very Dissatisfied

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

- 0 Not at all Noticeable
- 1 A Little
- 2 Somewhat
- 3 Much
- 4 Very Much Noticeable

6. How WORRIED/DISTRESSED are you about your current sleep problem?

- 0 Not at all Worried
- 1 A Little
- 2 Somewhat
- 3 Much
- 4 Very Much Worried

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

- 0 Not at all Interfering
- 1 A Little
- 2 Somewhat
- 3 Much
- 4 Very Much Interfering

Total score categories:

- 0–7 = No clinically significant insomnia
- 8–14 = Subthreshold insomnia
- 15–21 = Clinical insomnia (moderate severity)
- 22–28 = Clinical insomnia (severe)
# QoLIBRI-OS 2Wk

<table>
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<tr>
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**Test Completion Codes**

<table>
<thead>
<tr>
<th>Completion Code Other</th>
<th>Confounding Issues</th>
</tr>
</thead>
</table>

We would like to know **how satisfied** you are with different aspects of your life since your brain injury. For each question please choose the answer which is closest to how you feel now (including the past week). If you have problems filling out the questionnaire, please ask for help.

**These questions are about how you feel overall now (including the past week).**

1. Overall, how satisfied are you with your physical condition?

2. Overall, how satisfied are you with how your brain is working, in terms of your concentration, memory, thinking?

3. Overall, how satisfied are you with your feelings and emotions?

4. Overall, how satisfied are you with your ability to carry out day to day activities?

5. Overall, how satisfied are you with your personal and social life?

6. Overall, how satisfied are you with your current situation and future prospects?

**QoLIBRI-OS Total Score**

|----------------|-------------|---------------|---------|---------|

97
### MPAI4-M2PI 2Wk

**Patient Identification Information**

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**Test Completion Code**

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- 1.1 Non-standard adm - written
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- 2.2 Not completed - Non-neuro/phys
- 2.3 Not completed - Poor effort
- 2.4 Not completed - Language
- 2.5 Not completed - Illness
- 2.6 Not completed - Logistical
- 3.2 Not attempted - Non-neuro/phys
- 3.3 Not attempted - Poor effort
- 3.4 Not attempted - Language
- 3.5 Not attempted - Illness
- 3.6 Not attempted - Logistical
- 4.0 Not attempted - Examiner error
- 5.0 Other

**Test Completion Codes**

- Completion Code Other

**Confounding Issues**

Below each item, circle the number that best describes the level at which the person being evaluated experiences problems. Mark the greatest level of problem that is appropriate. Problems that interfere rarely with daily or valued activities, that is, less than 5% of the time, should be considered not to interfere. Write comments about specific items at the end of the rating scale.

**Person Reporting**

- Study participant
- Caregiver/Surrogate

**Participation**

1. Initiation: Problems getting started on activities without prompting
   - 0-None
   - 1-Mild problem but does not interfere with activities; may use assistive device or medication
   - 2-Mild problem; interferes with activities 5-24% of the time
   - 3-Moderate problem; interferes with activities 25-75% of the time
   - 4-Severe problem; interferes with activities more than 75% of the time

2. Social contact with friends, work associates, and other people who are not family, significant others, or professionals
   - 0-Normal involvement with others
   - 1-Mild difficulty in social situations but maintains normal involvement with others
   - 2-Mildly limited involvement with others (75-95% of normal interaction for age)
   - 3-Moderately limited involvement with others (25-74% of normal interaction for age)
   - 4-No or rare involvement with others (less than 25% of normal interaction for age)

3. Leisure and recreational activities
   - 0-Normal participation in leisure activities for age
   - 1-Mild difficulty in these activities but maintains normal participation
   - 2-Mildly limited participation (75-95% of normal participation for age)
   - 3-Moderately limited participation (25-74% of normal participation for age)
   - 4-No or rare participation (less than 25% of normal participation for age)

4. Self-care: Eating, dressing, bathing, hygiene
   - 0-Independent completion of self-care activities
   - 1-Mild difficulty, occasional omissions or mildly slowed completion of self-care; may use assistive device or require occasional prompting
   - 2-Requires a little assistance or supervision from others (5-24% of the time) including frequent prompting
   - 3-Requires moderate assistance or supervision from others (25-75% of the time)
   - 4-Requires extensive assistance or supervision from others (more than 75% of the time)

5. Residence: Responsibilities of independent living and homemaking (such as, meal preparation, home repairs and maintenance, personal health maintenance beyond basic hygiene including medical management) but not including managing money (see #8)
<table>
<thead>
<tr>
<th>Raw Score</th>
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### SWLS 2Wk

**Patient Identification Information**

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<th>Stop Time</th>
<th>Time Spent</th>
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**Test Completion Code**
- 1.0 Test completed in full - in person
- 1.1 Non-standard adm - written
- 1.2 Non-standard adm - other
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- 3.4 Not attempted - Language
- 3.5 Not attempted - Illness
- 3.6 Not attempted - Logistical
- 4.0 Not attempted - Examiner error
- 5.0 Other

**Completion Code Other**

**Confounding Issues**

---

**DIRECTIONS:** Below are five statements with which you may agree or disagree. Using the 1-7 scale, indicate your agreement with each item by selecting the appropriate number for that item. Please be open and honest in your responses.

1. In most ways my life is close to my ideal.

- 1- Strongly Disagree
- 2- Disagree
- 3- Slightly Disagree
- 4- Neither Agree nor Disagree
- 5- Slightly Agree
- 6- Agree
- 7- Strongly Agree

2. The conditions of my life are excellent.

- 1- Strongly Disagree
- 2- Disagree
- 3- Slightly Disagree
- 4- Neither Agree nor Disagree
- 5- Slightly Agree
- 6- Agree
- 7- Strongly Agree
3. I am satisfied with my life.

4. So far I have gotten the important things I want in life.

5. If I could live my life over, I would change almost nothing.

SWLS Total Score 101
SF-12 2Wk

**Patient Identification Information**

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Test administered in Spanish? [ ]

**Test Completion Code**

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- ¶ 5.0 Other

Test Completion Codes

<table>
<thead>
<tr>
<th>Completion Code Other</th>
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</thead>
</table>

Confounding Issues

---

**SF-12®:**

Answer every question by placing a check mark on the line in front of the appropriate answer. It is not specific for brain injury. If you are unsure about how to answer a question, please give the best answer you can and make a written comment beside your answer.

1. In general, would you say your health is:

- ¶ 1 - Excellent
- ¶ 2 - Very Good
- ¶ 3 - Good
- ¶ 4 - Fair
- ¶ 5 - Poor

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:

- ¶ 1 - Yes, Limited A Lot
- ¶ 2 - Yes,
3. Climbing SEVERAL flights of stairs:

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACHIEVED LESS than you would like:

5. Were limited in the KIND of work or other activities:

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACHIEVED LESS than you would like:

7. Didn’t do work or other activities as CAREFULLY as usual:

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work the home and housework)?

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful?

10. Did you have a lot of energy?
11. Have you felt downhearted and blue?

12. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?

SF-12 Total Score: 104
SF-12®:
Answer every question by placing a check mark on the line in front of the appropriate answer. It is not specific for brain injury. If you are unsure about how to answer a question, please give the best answer you can and make a written comment beside your answer.

1. In general, would you say your health is:
   - 1 - Excellent
   - 2 - Very Good
   - 3 - Good
   - 4 - Fair
   - 5 - Poor

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
   a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
      - 1 - Yes, Limited A Lot
      - 2 - Yes, Limited A Little
      - 3 - No, Not Limited At All
   b. Climbing several flights of stairs
      - 1 - Yes, Limited A Lot
3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

a. Accomplished less than you would like
   - 1-All of the time
   - 2-Most of the time
   - 3-Some of the time
   - 4-A little of the time
   - 5-None of the time

b. Were limited in the kind of work or other activities
   - 1-All of the time
   - 2-Most of the time
   - 3-Some of the time
   - 4-A little of the time
   - 5-None of the time

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

a. Accomplished less than you would like
   - 1-All of the time
   - 2-Most of the time
   - 3-Some of the time
   - 4-A little of the time
   - 5-None of the time

b. Did work or other activities less carefully than usual
   - 1-All of the time
   - 2-Most of the time
   - 3-Some of the time
   - 4-A little of the time
   - 5-None of the time

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
   - 1 - Not At All
   - 2 - A Little Bit
   - 3 - Moderately
   - 4 - Quite A Bit
   - 5 - Extremely

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks…

a. Have you felt calm and peaceful?
   - 1-All of the time
   - 2-Most of the time
   - 3-Some of the time
b. Did you have a lot of energy?

- 4-A little of the time
- 5-None of the time

<table>
<thead>
<tr>
<th>1-All of the time</th>
<th>2-Most of the time</th>
<th>3-Some of the time</th>
<th>4-A little of the time</th>
<th>5-None of the time</th>
</tr>
</thead>
</table>

c. Have you felt downhearted and depressed?

- 1-All of the time
- 2-Most of the time
- 3-Some of the time
- 4-A little of the time
- 5-None of the time

<table>
<thead>
<tr>
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<th>3-Some of the time</th>
<th>4-A little of the time</th>
<th>5-None of the time</th>
</tr>
</thead>
</table>

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- 1-All of the time
- 2-Most of the time
- 3-Some of the time
- 4-A little of the time
- 5-None of the time

<table>
<thead>
<tr>
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<th>2-Most of the time</th>
<th>3-Some of the time</th>
<th>4-A little of the time</th>
<th>5-None of the time</th>
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</table>
### Instructions

This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.

First, please answer a few questions about your worst event, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

### Have you experienced any very serious events like this?

- [ ] Yes  [ ] No

If yes: can you please briefly tell me what the event(s) was/were?

If you have not experienced a very stressful event like the ones described, identify the most stressful event you have ever...
experienced, and then complete the questionnaire using that event as your reference for the remaining questions about how much that event has bothered you.

Briefly identify the worst event if it is not described above:

How long ago did it happen? (please estimate if unsure)
- < 1 month
- 1-6 months
- 7-12 months
- 1-2yrs
- 3-5 yrs
- 6-10 yrs
- >10 yrs

Did it involve actual or threatened death, serious injury, or sexual violence?
- Yes
- No

How did you experience it?
- It happened to me directly
- I witnessed it
- I learned about it happening to a close family member or close friend
- I was repeatedly exposed to details about it as part of my job
- Other
  Please describe:

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?
- Accident or violence
- Natural causes
- Not applicable (no death)

Keeping this worst event in mind, read each of the problems on the next page and indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:

1. Repeated, disturbing, and unwanted memories of the stressful experience?
   - 0 Not at all
   - 1 A little bit
   - 2 Moderately
   - 3 Quite a bit
   - 4 Extremely

2. Repeated, disturbing dreams of the stressful experience?
   - 0 Not at all
   - 1 A little bit
   - 2 Moderately
   - 3 Quite a
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?

4. Feeling very upset when something reminded you of the stressful experience?

5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?

6. Avoiding memories, thoughts, or feelings related to the stressful experience?

7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?

8. Trouble remembering important parts of the stressful experience?
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?

10. Blaming yourself or someone else strongly for the stressful experience or what happened after it?

11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?

12. Loss of interest in activities that you used to enjoy?

13. Feeling distant or cut off from other people?

14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?
15. Irritable behavior, angry outbursts, or acting aggressively?

16. Taking too many risks or doing things that cause you harm?

17. Being “superalert” or watchful or on guard?

18. Feeling jumpy or easily startled?

19. Having difficulty concentrating?

20. Trouble falling or staying asleep?
PCL-5 Total Score
BSI-18 2Wk

Patient Identification Information

Date          Start Time  Stop Time  Time Spent

Test administered in Spanish?   

Test Completion Code

- 1.0 Test completed in full - in person
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- 3.5 Not attempted - Illness
- 3.6 Not attempted - Logistical
- 4.0 Not attempted - Examiner error
- 5.0 Other

Test Completion Codes

Completion Code Other

Confounding Issues

INSTRUCTIONS:

The BSI18 test consists of a list of problems people sometimes have. Read each one carefully and select the number of the response that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Do not skip any items. If you change your mind, select another answer. If you have any questions, please ask them now.

HOW MUCH WERE YOU DISTRESSED BY:

1. Faintness or dizziness
   - 0- Not at all
   - 1- A little bit
   - 2- Moderately
   - 3- Quite a bit
   - 4- Extremely

2. Feeling no interest in things
   - 0- Not at all
   - 1- A little bit
   - 2- Moderately
   - 3- Quite a bit
   - 4- Extremely

3. Nervousness or shakiness inside
   - 0- Not at all
   - 1- A little bit
<p>| | | | | |</p>
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<thead>
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<th></th>
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</thead>
<tbody>
<tr>
<td>4. Pains in heart or chest</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
<td>4- Extremely</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0- Not at all</td>
<td>1- A little bit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
<td></td>
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<tr>
<td></td>
<td>4- Extremely</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Feeling lonely</td>
<td>0- Not at all</td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
</tr>
<tr>
<td></td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
<td></td>
</tr>
<tr>
<td>6. Feeling tense or keyed up</td>
<td>0- Not at all</td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
</tr>
<tr>
<td></td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
<td></td>
</tr>
<tr>
<td>7. Nausea or upset stomach</td>
<td>0- Not at all</td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
</tr>
<tr>
<td></td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
<td></td>
</tr>
<tr>
<td>8. Feeling blue</td>
<td>0- Not at all</td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
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<tr>
<td></td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
<td></td>
</tr>
<tr>
<td>9. Suddenly scared for no reason</td>
<td>0- Not at all</td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
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<tr>
<td></td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
<td></td>
</tr>
<tr>
<td>10. Trouble getting your breath</td>
<td>0- Not at all</td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
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<tr>
<td></td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
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<tr>
<td>11. Feelings of worthlessness</td>
<td>0- Not at all</td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
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<tr>
<td></td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
<td></td>
</tr>
<tr>
<td>12. Spells or terror or panic</td>
<td>0- Not at all</td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
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<td></td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
<td></td>
</tr>
<tr>
<td>13. Numbness or tingling in parts of your body</td>
<td>0- Not at all</td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
</tr>
<tr>
<td></td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
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<tr>
<td>14. Feeling hopeless about the future</td>
<td>0- Not at all</td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
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<tr>
<td></td>
<td>1- A little bit</td>
<td>2- Moderately</td>
<td>3- Quite a bit</td>
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</tbody>
</table>
15. Feeling so restless you couldn't sit still
   □ 0- Not at all
   □ 1- A little bit
   □ 2- Moderately
   □ 3- Quite a bit
   □ 4- Extremely

16. Feeling weak in parts of your body
   □ 0- Not at all
   □ 1- A little bit
   □ 2- Moderately
   □ 3- Quite a bit
   □ 4- Extremely

17. Thoughts of ending your life
   □ 0- Not at all
   □ 1- A little bit
   □ 2- Moderately
   □ 3- Quite a bit
   □ 4- Extremely

18. Feeling fearful
   □ 0- Not at all
   □ 1- A little bit
   □ 2- Moderately
   □ 3- Quite a bit
   □ 4- Extremely

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<td>Anxiety</td>
<td></td>
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# PHQ-9 2Wk

## Patient Identification Information

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- 4.0 Not attempted - Examiner error
- 5.0 Other

### Test Completion Codes

- Completion Code Other

### Confounding Issues

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
   - 0 Not at all
   - 1 Several days
   - 2 More than half the days
   - 3 Nearly every day

2. Feeling down, depressed, or hopeless
   - 0 Not at all
   - 1 Several days
   - 2 More than half the days
   - 3 Nearly every day

3. Trouble falling or staying asleep, or sleeping too much
   - 0 Not at all
   - 1 Several days
   - 2 More than half the days
   - 3 Nearly every day

4. Feeling tired or having little energy
   - 0 Not at all
   - 1 Several days
1. Poor appetite or overeating

2. Feeling bad about yourself—or that you are a failure or have let yourself or your family down

3. Trouble concentrating on things, such as reading the newspaper or watching television

4. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual

5. Thoughts that you would be better off dead or of hurting yourself in some way

**Total Score:**

If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

**Total score categories:**

- 1-4 = Minimal depression
- 5-9 = Mild depression
- 10-14 = Moderate depression
- 15-19 = Moderately severe depression
- 20-27 = Severe depression
### C-SSRS 2Wk

**Patient Identification Information**

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**Confounding Issues**

### Suicidal Ideation

1. **Wish to be Dead**
   - **Lifetime**
     - Yes
     - No
   - **Recent**
     - Yes
     - No
   - If yes, describe:

2. **Non-Specific Active Suicidal Thoughts**
   - Yes
   - No

3. **Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act**
   - Yes
   - No

4. **Active Suicidal Ideation with Some Intent to Act, without Specific Plan**
   - Yes
   - No

5. **Active Suicidal Ideation with Specific Plan and Intent**
   - Yes
   - No

### Intensity of Ideation

**Most Severe Ideation**

<table>
<thead>
<tr>
<th>Lifetime</th>
<th>Recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>2</td>
<td>2</td>
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<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>5 Most Severe</td>
<td>5 Most Severe</td>
</tr>
</tbody>
</table>

**Description**

[Blank space for description]
<table>
<thead>
<tr>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than once a week</td>
</tr>
<tr>
<td>Once a week</td>
</tr>
<tr>
<td>2-5 times a week</td>
</tr>
<tr>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>Many times each day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fleeting</td>
</tr>
<tr>
<td>Some of the time</td>
</tr>
<tr>
<td>A lot of the time</td>
</tr>
<tr>
<td>Most of the day</td>
</tr>
<tr>
<td>Persistent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Controllability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easily able to control thoughts</td>
</tr>
<tr>
<td>Can control thoughts with little difficulty</td>
</tr>
<tr>
<td>Can control thoughts with some difficulty</td>
</tr>
<tr>
<td>Can control thoughts with a lot of difficulty</td>
</tr>
<tr>
<td>Unable to control thoughts</td>
</tr>
<tr>
<td>Does not attempt to control thoughts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deterrents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deterrents definitely stopped attempts</td>
</tr>
<tr>
<td>Deterrents probably stopped attempts</td>
</tr>
<tr>
<td>Uncertain that deterrents stopped attempts</td>
</tr>
<tr>
<td>Deterrents most likely did not stop attempts</td>
</tr>
<tr>
<td>Deterrents definitely did not stop attempts</td>
</tr>
<tr>
<td>Does not apply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for Ideation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely to get attention, revenge or reaction</td>
</tr>
<tr>
<td>Mostly to get attention, revenge or reaction</td>
</tr>
<tr>
<td>Equally to get attention and to stop/end the pain</td>
</tr>
<tr>
<td>Mostly to stop or end the pain</td>
</tr>
<tr>
<td>Does not apply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suicidal Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Attempt</td>
</tr>
<tr>
<td><strong>Lifetime</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>Recent</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Total # of Attempts</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Non-Suicidal Self-Injurious Behavior</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>If yes, describe:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Interrupted Attempt</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>If yes, describe:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total # of Interrupted Attempts</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Aborted Attempt</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>If yes, describe:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total # of Aborted Attempts</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Preparatory Acts or Behavior</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>If yes, describe:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Suicidal Behavior Present</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actual Lethality/Medical Damage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Most Recent Attempt</strong></td>
</tr>
<tr>
<td>No physical damage (or very minor)</td>
</tr>
<tr>
<td>Minor physical damage</td>
</tr>
<tr>
<td>Moderate physical damage</td>
</tr>
<tr>
<td>Moderately severe physical</td>
</tr>
<tr>
<td><strong>Most Lethal Attempt</strong></td>
</tr>
<tr>
<td>No physical damage (or very minor)</td>
</tr>
<tr>
<td>Minor physical damage</td>
</tr>
<tr>
<td>Moderate physical damage</td>
</tr>
<tr>
<td>Moderately severe physical</td>
</tr>
<tr>
<td><strong>Initial Attempt</strong></td>
</tr>
<tr>
<td>No physical damage (or very minor)</td>
</tr>
<tr>
<td>Minor physical damage</td>
</tr>
<tr>
<td>Moderate physical damage</td>
</tr>
<tr>
<td>Moderately severe physical</td>
</tr>
</tbody>
</table>

https://studydata.net/qgen/YFormPrint.php?FormName=CSSRS2Wk
<table>
<thead>
<tr>
<th>Potential Lethality</th>
<th>Damage</th>
<th>Damage</th>
<th>Damage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Severe physical damage</td>
<td>Death</td>
<td>Severe physical damage</td>
</tr>
<tr>
<td></td>
<td>Not likely to result in injury</td>
<td>Likely to result in injury but not death</td>
<td>Likely to result in death</td>
</tr>
</tbody>
</table>
# Adverse Events

<table>
<thead>
<tr>
<th>Patient Identification Information</th>
</tr>
</thead>
</table>

### Start Date Time

<table>
<thead>
<tr>
<th>End Date Time</th>
</tr>
</thead>
</table>

### Severity

- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Life-threatening/Disabling
- [ ] Fatal/Death

### Describe Event

<table>
<thead>
<tr>
<th>During which procedure did the adverse event occur?</th>
</tr>
</thead>
</table>
| • Outcomes Testing
| • Research MRI
| • Blood Draw
| • Other
| Please specify other: |

### Relatedness to study?

- [ ] Unlikely
- [ ] Probable
- [ ] Possible
- [ ] Definite

### Action Taken with Study Intervention

- [ ] None
- [ ] Study Intervention Interrupted
- [ ] Study Intervention Discontinued
- [ ] Study Intervention Modified

### Other Action Taken

- [ ] None
- [ ] Non-Study Treatment Required

### Outcome

- [ ] Recovered/Resolved
- [ ] Recovered/Resolved With Sequelae
- [ ] Recovering/Resolving
- [ ] Not Recovered/Not Resolved
- [ ] Fatal
- [ ] Unknown

### Serious Adverse Event?

- [ ] Yes
- [ ] No