TRACK-TBI

Transforming Research and Clinical Knowledge in Traumatic Brain Injury

International Traumatic Brain Injury Research Initiative

Case Report Forms

Outcomes

Ortho Control

Patients

Table of Contents

CLINICAL PROTOCOL GRID

CA	CA+MRI/HDFT	Procedure	Admission	Hospital	2W	3M*	6M	12M
♦	♦	Admission Data	X	X+				
♦	♦	Blood (DNA, Biomarkers)	X (optional repeat @ 3-6h)					
♦	♦	Blood (Biomarkers)		X (day 3,5)+	X		X	
♦	♦	Daily Clinical Data	X+	X (daily)+				
♦	♦	High Resolution ICU Data	X¥	X (daily)¥				
♦	♦	CSF (Biomarkers, optional)		X (days 1-7)¥				
♦	♦	Clinical Brain CT (and MRI)	X	X (all)+				
	♦	3T Research Brain MRI			X		X	
♦	♦	Outcomes: Full Battery			X	X	X	X

* Outcomes administration at the 3M time conducted only by telephone

\+ Collected only for those admitted to the Ward or ICU

¥ Collected only for those admitted to the ICU

Patient Management

Patient Identification Information

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Coding for "Did Pt Show Up" , Enter N/A if pt has expired or withdrawn.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Leave blank if withdrawn or died before window closed.)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

	Appt Due Date	Scheduled Date Time	Did the patient show up?	Appointment Outcome	Transport	Transport Reimbursement ($)	Person Responsible for appt
2 Week Outcomes			☐ Yes ☐ No ☐ N/A	☐ CA PhoneOnly ☐ CA Completed Full(AAB or CAB) ☐ CA Partial ☐ Missed Milestone ☐ GOSE-Phone Only	☐ Needs transport ☐ Self transport		
	Time since injury:						
2 Week MRI			☐ Yes ☐ No ☐ N/A	☐ Completed Full Protocol ☐ Completed Partial Protocol ☐ Missed Milestone ☐ Missed Milestone - Pt Factors ☐ Missed Milestone - Tech Factors	☐ Needs transport ☐ Self transport		
	Time since injury:						
3 Month Outcomes			☐ Yes ☐ No ☐ N/A	☐ CA Completed Full (AAB or CAB) ☐ CA Partial ☐ Missed Milestone ☐ GOSE Only			
	Time since injury:						
6 Month Outcomes			☐ Yes ☐ No ☐ N/A	☐ CA Phone Only ☐ CA Completed Full (AAB or CAB) ☐ CA Partial ☐ Missed Milestone ☐ GOSE-Phone Only	☐ Needs transport ☐ Self transport		
	Time since injury:						
6 Month MRI			☐ Yes ☐ No ☐ N/A	☐ Completed Full Protocol ☐ Completed Partial Protocol ☐ Missed Milestone ☐ Missed Milestone - Pt Factors ☐ Missed Milestone - Tech Factors	☐ Needs transport ☐ Self transport		
	Time since injury:						
6 Month BTACT			☐ Yes ☐ No ☐ N/A	☐ Completed ☐ Partial ☐ Missed Milestone			
	Time since injury:						
12 Month			☐ Yes	☐ CA Phone Only	☐ Needs		

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Outcomes

- [ ] No
- [ ] N/A

- [ ] CA Completed Full (AAB or CAB)
- [ ] CA Partial
- [ ] Missed Milestone
- [ ] GOSE-Phone Only

transport
- [ ] Self transport

Time since injury:

Biospecimens Collected and ID's

	Date Collected	Time	RNA	Plasma	Serum	DNA	Abbott Serum	Track Add-On	Abbott Plasma
Baseline			Yes / No	Yes / No	Yes / No	Yes / No	Yes / No		
3 to 6 Hrs							Yes / No	Yes / No	Yes / No
Hospital 1			Yes / No	Yes / No	Yes / No				
Hospital 2			Yes / No	Yes / No	Yes / No				
2 Week			Yes / No	Yes / No	Yes / No				
6 Month			Yes / No	Yes / No	Yes / No				

Biospecimen Notes

Imaging Notes

Follow Up Notes

CSF ID (e.g. CS-03-1001, if applicable):

Abbott ID (e.g. AL-03-1001, if applicable):

Friend Control ID (e.g. FC-03-1001, if applicable):

Contact and Communications Log

Date and Time of Contact	Reason	Method	Notes (describe contact and initial)
	Consent Schedule Appt Appt Reminder Reschedule Appt Reschedule Missed Appt Reimbursement MRI Results General Check-in Other (describe in Notes)	Spoke to Patient Spoke to Relative Spoke to Other Left Voice Message No Answer Bad Number Email Postal Mail Text Message Other (describe in Notes)	
	Consent Schedule Appt Appt Reminder Reschedule Appt Reschedule Missed Appt Reimbursement MRI Results General Check-in Other (describe in Notes)	Spoke to Patient Spoke to Relative Spoke to Other Left Voice Message No Answer Bad Number Email Postal Mail Text Message Other (describe in Notes)	
	Consent Schedule Appt Appt Reminder Reschedule Appt Reschedule Missed Appt Reimbursement MRI Results General Check-in Other (describe in Notes)	Spoke to Patient Spoke to Relative Spoke to Other Left Voice Message No Answer Bad Number Email Postal Mail Text Message Other (describe in Notes)	
	Consent Schedule Appt Appt Reminder Reschedule Appt Reschedule Missed Appt Reimbursement	Spoke to Patient Spoke to Relative Spoke to Other Left Voice Message No Answer Bad Number Email	

	☐ MRI Results ☐ General Check-in ☐ Other (describe in Notes)	☐ Postal Mail ☐ Text Message ☐ Other (describe in Notes)	
	☐ Consent ☐ Schedule Appt ☐ Appt Reminder ☐ Reschedule Appt ☐ Reschedule Missed Appt ☐ Reimbursement ☐ MRI Results ☐ General Check-in ☐ Other (describe in Notes)	☐ Spoke to Patient ☐ Spoke to Relative ☐ Spoke to Other ☐ Left Voice Message ☐ No Answer ☐ Bad Number ☐ Email ☐ Postal Mail ☐ Text Message ☐ Other (describe in Notes)	

Contact Info

Home Phone

Email

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

Sample ID (Subject)	Visit	Material Type	Material Modifier	Date/Time Drawn	Date/Time Processed	Date/Time Frozen	Date/Time Shipped
	Day 1 Day 3 Day 5 2 Weeks 6 Months	Plasma Buffy Coat Serum Whole Blood	EDTA SST PAXgene				
	Day 1 Day 3 Day 5 2 Weeks 6 Months	Plasma Buffy Coat Serum Whole Blood	EDTA SST PAXgene				
	Day 1 Day 3 Day 5 2 Weeks 6 Months	Plasma Buffy Coat Serum Whole Blood	EDTA SST PAXgene				
	Day 1 Day 3 Day 5 2 Weeks 6 Months	Plasma Buffy Coat Serum Whole Blood	EDTA SST PAXgene				
	Day 1 Day 3 Day 5 2 Weeks 6 Months	Plasma Buffy Coat Serum Whole Blood	EDTA SST PAXgene				

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?
(Enter N/A if your site is not doing 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?
Yes No

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

Axial DTI Completed?
Yes 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?
Yes 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?
Yes 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?
Yes 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	
CA + MRI Cohort	MRI: 14 days post-injury ± 4 days
	Outcomes: ± 3 days of 2-week MRI
CA/BA Cohorts	Outcomes: 14 days post-injury ± 4 days

3 Month Telephone Follow-up Assessment Window	
All Cohorts	Outcomes: 90 days post-injury ± 7 days

6 Month Follow-up Assessment Windows	
CA + MRI Cohort	MRI: 180 days post-injury ± 14 days
	Outcomes: ± 14 days of 6-month MRI
	BTACT: ± 7 days of Outcomes (but not on the same day)
CA/BA Cohorts	Outcomes: 180 days post-injury ± 14 days
	BTACT: ± 7 days of Outcomes (but not on the same day)

12 Month Follow-up Assessment Window	
All Cohorts	Outcomes: 360 days post-injury ± 30 days

Flexible Outcome Assessment Battery Framework Table

Domain	Outcome Measure	Estimated Completion Time	Comprehensive Assessment (CA) Cohort	Brief Assessment (BA) Cohort
Screening Protocol (5-9 minutes)				
Screening	• 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)**				

Participant/ Surrogate Interviews	• 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

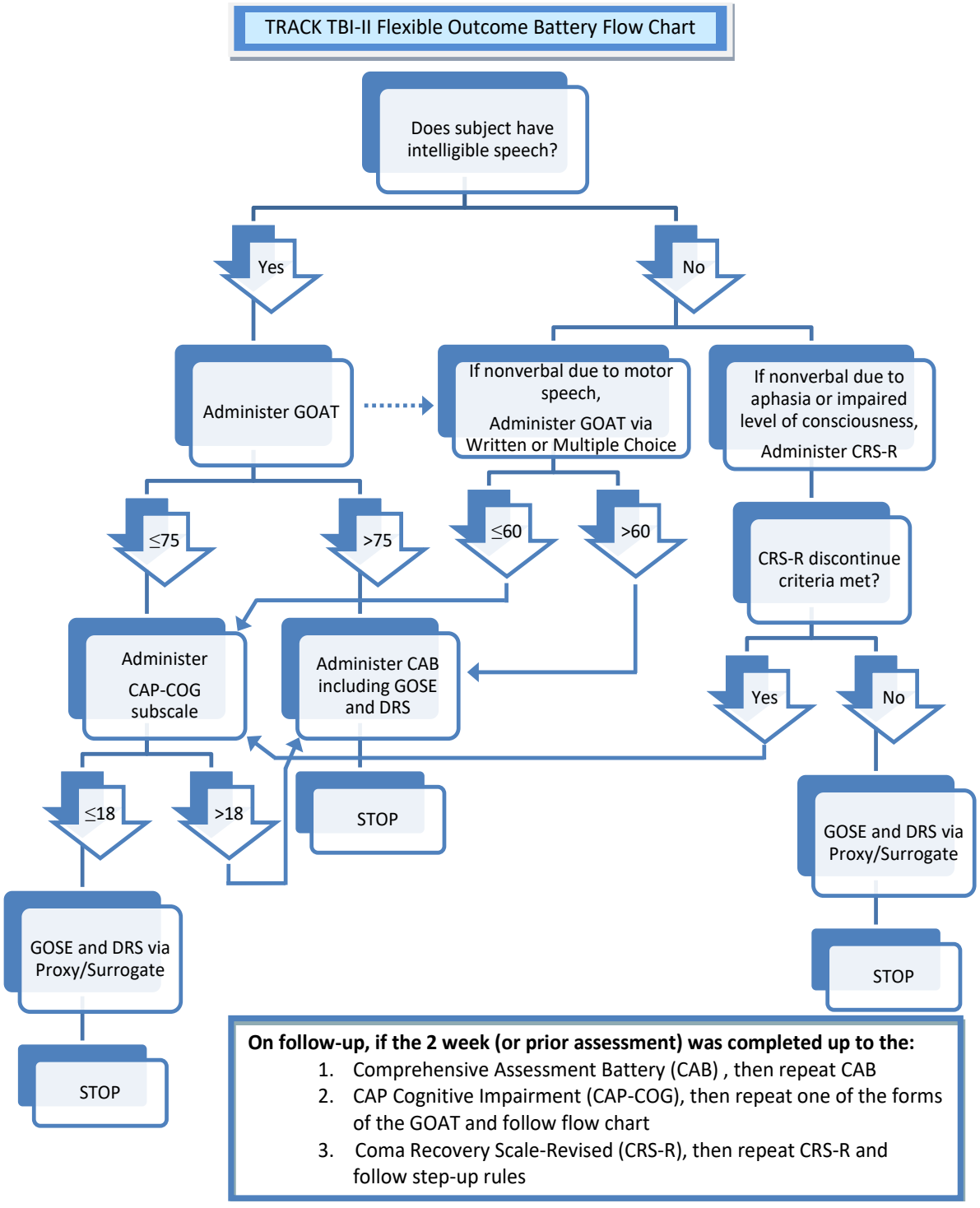
Consciousness and Basic Cognition	• Confusion Assessment Protocol (CAP) • Coma Recovery Scale Revised (CRS-R)	15m 15-30m	2W, 6M, 12M	N/A
Global Outcome	• Revised-Glasgow Outcome Scale Extended (RGOSE) • Expanded Disability Rating Scale Post-Acute Interview (E-DRS-PI)	8m 5-15m	2W, 3M (T), 6M, 12M	RGOSE **only** 2W (T), 3M (T), 6M (T), 12M (T)
Comprehensive Assessment Battery (CAB) **(136-148 minutes- includes screening; excludes BTACT)**				
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	N/A

Participant/ Surrogate Interviews	• 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 ---------- 6M (T)	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.



Test Completion Codes

Test Attempted and completed	
1.0	Test completed in full, in person- results valid
1.1	Non-standard administration – a measure normally requiring an oral response, allowed a written response, results valid
1.2	Non-standard administration –Other (specify):_____
1.3	Test Completed, valid administration done over the phone
Test Attempted but NOT completed	
2.1	Test attempted but not completed due to cognitive/neurological reason
2.2	Test attempted but not completed due to non-neurological/physical reasons
2.3	Test attempted but not completed - participant cognitively intact enough to respond but poor effort, random responding, rote response, not cooperative, refusal, intoxication
2.4	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)
2.5	Test attempted but not completed due to test interrupted by illness and test could not be completed later
2.6	Test attempted but not completed due to logistical reasons, other reasons – site specific
Test not attempted	
3.1	Test not attempted due to severity of cognitive/neurological deficits
3.2	Test not attempted due to non-neurological/physical reasons
3.3	Test not attempted - participant can respond appropriately but poor effort, not cooperative, refusal, intoxication
3.4	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)
3.5	Test not attempted due to participant illness and test could not be completed later
3.6	Test not attempted due to logistical reasons, other reasons – site specific
4.0	Test not attempted, completed or valid due to examiner error
5.0	Other (specify:_____)

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

Test Completion Code Speech
- ☐ 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 - Logstical
- ☐ 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

Speech Completion Code Other

Confounding Issues

Type of GOAT administered
- ☐ Standard GOAT
- ☐ Written GOAT
- ☐ Modified GOAT
- ☐ Not administered

Test Completion Code GOAT
- ☐ 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 - Logstical
- ☐ 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 Code Written GOAT
- ☐ 1.0 Test completed in full
- ☐ 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 - Logstical
- ☐ 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 Code Modified GOAT
- ☐ 1.0 Test completed in full
- ☐ 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 - Logstical
- ☐ 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 - Logstical
- ☐ 4.0 Not attempted - Examiner error
- ☐ 5.0 Other

GOAT Completion Code Other | Written GOAT Completion Code Other | Modified GOAT Completion Code Other | GOAT Not Ac

Confounding Issues | Confounding Issues | Confounding Issues

PTA Administered ☐ Yes ☐ No

Test Completion Code PTA
- ☐ 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 - Logstical
- ☐ 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

PTA Test Comp Code Other

PTA Confounding Issues

Test Completion Codes

Speech Intelligibility

Date | Start Time | Stop Time | Time Spent

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 (ie, 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

Date | Start Time | Stop Time | Time Spent

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

When were you born?
☐ No Error
☐ Error (-4)

Where do you live?
☐ No Error
☐ Error (-4)

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

(b) Building
☐ No Error
☐ Error (-5)

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

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

4. What is the first event you can remember after the injury?
☐ No Error
☐ Error (-5)

Can you give some detail?
☐ No Error
☐ Error (-5)

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

Can you give some detail?
☐ No Error
☐ Error (-5)

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
☐ One day error (-1)
☐ Two day error (-2)
☐ Three day error (-3)

8. 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)

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

10. 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 = (100 - total error) = 100 - _____ =

Calculates on Save

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

Written GOAT

Date	Start Time	Stop Time	Time Spent

1. What is your name?	☐ No Error ☐ Error (-2)
When were you born?	☐ No Error ☐ Error (-4)
Where do you live?	☐ No Error ☐ Error (-4)
2. Where are you now: (a) City	☐ No Error ☐ Error (-5)
(b) Building	☐ No Error ☐ Error (-5)
3. On what date were you admitted to the hospital?	☐ No Error ☐ Error (-5)
How did you get here?	☐ No Error ☐ Error (-5)
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 ☐ One day error (-1) ☐ Two day error (-2) ☐ Three day error (-3)
8. 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)
9. What is the month?	☐ No Error ☐ One month error (-5) ☐ Two month error (-10) ☐ Three or more month error (-15)
10. 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 - _____ =

Calculates on Save

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

Modified GOAT

Date	Start Time	Stop Time	Time Spent

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 (-5)
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)

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)

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 - _____ =

Calculates on Save

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 ☐ CAP Done ☐ CRS-R Done
○ Abbreviated Battery
○ Comprehensive Assessment Battery
○ BA

******Please return to the Subject List and select the Subject again to display the assigned Battery Group******

Modified GOS-E 2Wk CONTROL

Patient Identification Information

Date | Start Time | Stop Time | Time Spent

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

Form Completion Status
- ☐ Not Started
- ☐ In Process
- ☐ Complete
- ☐ Not Complete
- ☐ Incompletable - No Show
- ☐ Incompletable - Pt Factors

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 (for controls) was created to document the impact peripheral or non-CNS injuries have on a participant's functional outcome in major areas of life.

(*If a new injury occurs after the study injury, include the *cumulative effects of all brain and peripheral injuries* in the 'All' rating.

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.)?
- ☐ 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

Independence outside home:

3a. Are you able to shop without assistance?

- ☐ No (Upper SD All)
- ☐ Yes - go to 4a

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 you able to shop without assistance before the injury?

- ☐ No
- ☐ 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

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)

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 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)

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

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 injury: numbness, weakness, mobility problems, inability to use extremity, tiredness, memory failures, 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.

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.

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)

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

GOSE Audit Log

1. Reviewer: Record Status of Review

Initials Date

- ☐ 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)

Specify other:

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

DRS Caregiver 2Wk

Patient Identification Information

Date | Start Time | Stop Time | Time Spent

Responder ☐ Caregiver

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
- ☐ 2.2 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 - Logstical
- ☐ 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

1.0 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):
- ☐ 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

3.2 How do they communicate primarily?
☐ 0-Speech

	☐ 1-Writing or spelling device ☐ 2-Gestures or signals
3.3 Is [name] 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
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?	☐ 0-No ☐ 1-Yes
3.5 Does [name] only moan, groan or make other sounds that are not understandable?	☐ 0-No ☐ 1-Yes

4.0 Feeding

4.1 Can [name] feed him/herself independently or manage tube feedings appropriately without help or reminders?	☐ 0-Yes ☐ 1-No
4.2 Does [name] understand what eating or feeding utensils or equipment are for and how they should be used?	☐ 0-Always ☐ 1-Most of the time ☐ 2-Some of the time ☐ 3-Never
4.3 Does [name] know when meal or feeding times are?	☐ 0-Always ☐ 1-Most of the time ☐ 2-Some of the time ☐ 3-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?	☐ 0-Yes ☐ 1-No
5.2 Does [name] understand how to manage their clothing or special equipment when toileting or in bowel and bladder management?	☐ 0-Always ☐ 1-Most of the time ☐ 2-Some of the time ☐ 3-Never
5.3 Does [name] know when to use the toilet or to conduct bowel and bladder management?	☐ 0-Always ☐ 1-Most of the time ☐ 2-Some of the time ☐ 3-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?	☐ 0-Yes ☐ 1-No
6.2 Does [s/he] know how to bathe and wash?	☐ 0-Always ☐ 1-Most of the time ☐ 2-Some of the time ☐ 3-Never
6.3 Does [s/he] understand how to get dressed?	☐ 0-Always ☐ 1-Most of the time ☐ 2-Some of the time ☐ 3-Never
6.4 Can [s/he] start and finish these grooming activities without prompting?	☐ 0-Always ☐ 1-Most of the time ☐ 2-Some of the time ☐ 3-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?	☐ 1-No ☐ 0-Yes
7.2 Does [name] REQUIRE special aids or equipment such as a brace, walker,	☐ 0-No

wheelchair, memory notebook, day planner, verbal reminders, prompts, cues, or alarm watch because of a disability?	☐ 1-Yes
7.3 Does [name] require physical assistance from another person to meet daily needs?	☐ 0-Never ☐ 1-Some of the time ☐ 2-Most 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

30

☐ 2-Certain or very certain s/he cannot

SCORING COMING SOON

Sum scores based on algorithm for items:

Item 2	
Item 4	
Item 5	
Item 6	
Item 7	
Item 8	
DRS-PI Score	
Subtotal = DRS-PI + sum(7.1 thu 8.4):	
Add score for Employment Category	
Expanded DRS-PI Score	

DRS Survivor 2Wk

Patient Identification Information

Date | Start Time | Stop Time | Time Spent

Responder ☐ Self

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
- ☐ 2.2 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 - Logstical
- ☐ 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

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

4.2 Do you understand what eating or feeding utensils or equipment are for and how they should be used?
- ☐ 0-Always
- ☐ 1-Most of the time
- ☐ 2-Some of the time
- ☐ 3-Never

4.3 Do you know when meal or feeding times are?
- ☐ 0-Always
- ☐ 1-Most of the time
- ☐ 2-Some of the time
- ☐ 3-Never

5.0 Toileting

5.1 Can you use the toilet or manage your bowel and bladder routine
- ☐ 0-Yes

independently and appropriately without help or reminders?
- 1-No

5.2 Do you understand how to manage your clothing or special equipment when toileting or in bowel and bladder management?
- 0-Always
- 1-Most of the time
- 2-Some of the time
- 3-Never

5.3 Do you know when to use the toilet or to conduct bowel and bladder management?
- 0-Always
- 1-Most of the time
- 2-Some of the time
- 3-Never

6.0 Grooming

6.1 Can you dress and groom yourself independently and appropriately or direct someone else in these activities without help or reminders?
- 0-Yes
- 1-No

6.2 Do you know how to bathe and wash?
- 0-Always
- 1-Most of the time
- 2-Some of the time
- 3-Never

6.3 Do you understand how to get dressed?
- 0-Always
- 1-Most of the time
- 2-Some of the time
- 3-Never

6.4 Can you start and finish these grooming activities without prompting?
- 0-Always
- 1-Most of the time
- 2-Some of the time
- 3-Never

7.0 Level of Functioning

7.1 Do you function completely independently? That is, you do not require any physical assistance, supervision, equipment, devices or reminders for cognitive, social, behavioral, emotional, and physical function?
- 1-No
- 0-Yes

7.2 Do you 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?
- 0-No
- 1-Yes

7.3 Do you require physical assistance from another person to meet daily needs?
- 0-Never
- 1-Some of the time
- 2-Most of the time
- 3-Always

7.4 Do you 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 Do you 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 Do you take care of some of your needs but also need a helper who is always close by?
- 0-No
- 1-Yes

7.6b Do you need help with all major activities and the assistance of another person all the time?
- 0-No
- 1-Yes

7.6c Do you need 24-hour care and is not able to help with your own care at all?
- 0-No
- 1-Yes

8.0 Employability

8.1 Can you 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 you understand, remember, and follow directions?	☐ 0-Always ☐ 1-Most of the time ☐ 2-Some of the time ☐ 3-Never
8.3 Can you 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 you can perform in a wide variety of jobs of your 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 you 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 you 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 you 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 ☐ 2-Certain or very certain s/he cannot

SCORING COMING SOON

Sum scores based on algorithm for items:

Item 2	
Item 4	
Item 5	
Item 6	
Item 7	
Item 8	
DRS-PI Score	
Subtotal = DRS-PI + sum(7.1 thu 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 | 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 - Logstical
- 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
   - Unknown. Skip to question 4

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:

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)
- ☐ 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

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
☐ N/A Worked in last 7 days
☐ Still in hospital
☐ Unknown
Other, please specify:

9. How many hours altogether did you work in the past 7 days (fill in number of hours 1 to 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

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)?

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

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. Since your injury, 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
☐ No
☐ Yes
☐ Unknown
☐ N/A

2. Part-time or reduced hours
☐ No
☐ Yes
☐ Unknown
☐ N/A

3. Modified schedule
☐ Yes
☐ No
☐ Unknown
☐ N/A

4. Transfer to a different job with different tasks
☐ No
☐ Yes
☐ Unknown
☐ N/A

5. Equipment/assistive technology to help perform the job
☐ No
☐ Yes
☐ Unknown
☐ N/A

6. Job coaching/mentor to be able to do job
☐ No
☐ Yes

Unknown
N/A

14. Did you attend school in the last week? (choose one)
- No
- Yes
- N/A not a student pre-injury and no plans to attend
- Unknown

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

Is patient still hospitalized?
- No
- Yes

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?
- No
- Yes
- Unknown

Type of healthcare provider: (If yes, check all that apply)	Did it help?
General practitioner (primary care)	No / Yes / Unknown
TBI/Concussion Clinic	No / Yes / Unknown
Neurologist	No / Yes / Unknown
Physiatrist	No / Yes / Unknown
Chiropractor	No / Yes / Unknown
Psychiatrist	No / Yes / Unknown
Psychologist, psychological services	No / Yes / Unknown
Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.)	No / Yes / Unknown
Other Other, please specify	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)	Did it help?
☐ General practitioner (primary care)	☐ No ☐ Yes ☐ Unknown
☐ Cardiologist	☐ No ☐ Yes ☐ Unknown
☐ Orthopedics	☐ No ☐ Yes ☐ Unknown
☐ Oral and maxillofacial Surgery	☐ No ☐ Yes ☐ Unknown
☐ Plastic Surgery	☐ No ☐ Yes ☐ Unknown
☐ ENT	☐ No ☐ Yes ☐ Unknown
☐ Other Other, please specify:	☐ No ☐ Yes ☐ Unknown

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	☐ 1-2 days per week ☐ 3-5 days per week
Occupational therapy	☐ 1-2 days per week ☐ 3-5 days per week
Speech therapy	☐ 1-2 days per week ☐ 3-5 days per week
Therapeutic recreation	☐ 1-2 days per week ☐ 3-5 days per week
Cognitive remediation	☐ 1-2 days per week ☐ 3-5 days per week
Psychological services	☐ 1-2 days per week ☐ 3-5 days per week
Nursing services	☐ 1-2 days per week ☐ 3-5 days per week
Peer mentoring	☐ 1-2 days per week ☐ 3-5 days per week
Social work/Case management	☐ 1-2 days per week

	☐ 3-5 days per week
Independent living training	☐ 1-2 days per week ☐ 3-5 days per week
Other	☐ 1-2 days per week ☐ 3-5 days per week
	Other, please specify:
Did you receive more than two different therapy services at the same time?	☐ No ☐ Yes ☐ Unknown

23. Were you treated as an **outpatient** for problems related to your brain injury? ☐ No, skip to Question 24
☐ Yes

Start Date:	
Active Outpatient Rehab Ongoing	☐ No ☐ Yes
End Date:	
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	☐ 1-2 days per week ☐ 3-5 days per week
Occupational therapy	☐ 1-2 days per week ☐ 3-5 days per week
Speech therapy	☐ 1-2 days per week ☐ 3-5 days per week
Therapeutic recreation	☐ 1-2 days per week ☐ 3-5 days per week
Cognitive remediation	☐ 1-2 days per week ☐ 3-5 days per week
Educational services	☐ 1-2 days per week ☐ 3-5 days per week
Vocational services	☐ 1-2 days per week ☐ 3-5 days per week
Psychological services	☐ 1-2 days per week ☐ 3-5 days per week
Nursing services	☐ 1-2 days per week ☐ 3-5 days per week
Peer mentoring	☐ 1-2 days per week ☐ 3-5 days per week
Social work/Case management	☐ 1-2 days per week ☐ 3-5 days per week
Independent living training	☐ 1-2 days per week ☐ 3-5 days per week
Home health aide	☐ 1-2 days per week ☐ 3-5 days per week
Other	☐ 1-2 days per week ☐ 3-5 days per week Other, please specify:
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 ☐ 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

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?
- [ ] No
- [ ] Yes
- [ ] Unknown

Type of therapy: (check all that apply)	Did it help?
Inpatient Rehabilitation	
☐ Physical Therapy	☐ No ☐ Yes ☐ Unknown
☐ Occupational Therapy	☐ No ☐ Yes ☐ Unknown
☐ Other Other, please specify:	☐ No ☐ Yes ☐ Unknown
Outpatient Rehabilitation	
☐ Physical Therapy	☐ No ☐ Yes ☐ Unknown
☐ Occupational Therapy	☐ No ☐ Yes ☐ Unknown
☐ Other Other, please specify:	☐ No ☐ Yes ☐ Unknown

26. Overall how satisfied are you with the availability of support from people close to you since the injury?
- [ ] Not at all
- [ ] Slightly
- [ ] Moderately
- [ ] Quite
- [ ] Very
- [ ] Unknown

27. Overall how satisfied are you with the help you got from people at the hospital at the time of your injury?
- [ ] Not at all
- [ ] Slightly
- [ ] Moderately
- [ ] Quite
- [ ] Very
- [ ] Unknown

28. Overall how satisfied are you with the health care services you got 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

29. Do you think you need more health care services than you received?
- [ ] No
- [ ] Yes
- [ ] Unknown
- [ ] Not at all

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

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?
- 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

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?** 'We are wanting to know about drugs like marijuana, crack or heroin;
- No

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.'

42 ☐ 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 (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

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 - Logstical
- 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
   - Unknown. Skip to question 4

   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:

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)
- ☐ 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

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
- N/A worked in last 7 days
- Still in Hospital
- Unknown

Other, please specify:

9. How many hours altogether did you work in the past 7 days (fill in number of hours 1 to 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

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)?

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

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)

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
   - No
   - Yes
   - Unknown
   - N/A
2. Part-time or reduced hours
   - No
   - Yes
   - Unknown
   - N/A
3. Modified schedule
   - No
   - Yes
   - Unknown
   - N/A
4. Transfer to a different job with different tasks
   - No
   - Yes
   - Unknown
   - N/A
5. Equipment/assistive technology to help perform the job
   - No
   - Yes
   - Unknown
   - N/A
6. Job coaching/mentor to be able to do job
   - No
   - Yes

	☐ Unknown ☐ N/A
14. Did you attend school in the last week? (choose one)	☐ No ☐ Yes ☐ N/A not a student pre-injury and no plans to attend ☐ Unknown
15. What is the main reason you did not attend school in the past week? (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 ☐ 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 * 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 – 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)	☐ 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 within the last 3 months for your traumatic brain injury?	☐ No ☐ Yes ☐ Unknown

Type of healthcare provider: *(If yes, check all that apply)*	Did it help?
☐ General practitioner (primary care)	☐ No ☐ Yes ☐ Unknown
☐ TBI/Concussion Clinic	☐ No ☐ Yes ☐ Unknown
☐ Neurologist	☐ No ☐ Yes ☐ Unknown
☐ Physiatrist	☐ No ☐ Yes ☐ Unknown
☐ Chiropractor	☐ No ☐ Yes ☐ Unknown
☐ Psychiatrist	☐ No ☐ Yes ☐ Unknown
☐ Psychologist, psychological services	☐ No ☐ Yes ☐ Unknown
☐ Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.)	☐ No ☐ Yes ☐ Unknown
☐ Other Other, please specify	☐ No ☐ Yes ☐ Unknown

20. Have you seen any healthcare provider in the last 3 months ☐ No

for any peripheral injuries (e.g. fractured limbs, eye injuries, etc.)?
- ☐ Yes
- ☐ Unknown

Type of healthcare provider: *(If yes, check all that apply)*	Did it help?
☐ General practitioner (primary care)	☐ No ☐ Yes ☐ Unknown
☐ Cardiologist	☐ No ☐ Yes ☐ Unknown
☐ Orthopedics	☐ No ☐ Yes ☐ Unknown
☐ Oral and maxillofacial Surgery	☐ No ☐ Yes ☐ Unknown
☐ Plastic Surgery	☐ No ☐ Yes ☐ Unknown
☐ ENT	☐ No ☐ Yes ☐ Unknown
☐ Other Other, please specify:	☐ No ☐ Yes ☐ Unknown

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

Peer mentoring	☐ Unknown ☐ No ☐ Yes
Social work/Case management	☐ Unknown ☐ No ☐ Yes
Independent living training	☐ Unknown ☐ No ☐ Yes
Other	☐ Unknown ☐ No ☐ Yes ☐ Unknown Other, please specify:
Did you receive more than two different therapy services at the same time?	☐ No ☐ Yes ☐ Unknown

23. Were you treated as an **outpatient** for problems related to your brain injury? ☐ No, skip to Question 24 ☐ 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
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 ☐ Unknown ☐ Home (i.e. therapist comes to person's home) ☐ Other 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
Educational services	☐ No ☐ Yes ☐ Unknown
Vocational services	☐ No ☐ Yes ☐ Unknown
Psychological services	☐ No ☐ Yes ☐ Unknown
Nursing services	☐ No ☐ Yes ☐ Unknown
Peer mentoring	☐ No ☐ Yes ☐ Unknown
Social work/Case management	☐ No ☐ Yes ☐ Unknown
Independent living training	☐ No

	☐ Yes ☐ Unknown
Home health aide	☐ No ☐ Yes ☐ Unknown
Other	☐ No ☐ Yes ☐ Unknown Other, please specify:
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 than 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 ☐ 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

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

Type of therapy: (check all that apply)	Did it help?
Inpatient Rehabilitation	
☐ Physical Therapy	☐ No ☐ Yes ☐ Unknown
☐ Occupational Therapy	☐ No ☐ Yes ☐ Unknown
☐ Other Other, please specify:	☐ No ☐ Yes ☐ Unknown
Outpatient Rehabilitation	

☐ Physical Therapy	☐ No ☐ Yes ☐ Unknown	
☐ Occupational Therapy	☐ No ☐ Yes ☐ Unknown	
☐ Other Other, please specify:	☐ No ☐ Yes ☐ Unknown	

26. Overall how satisfied are you with the availability of support from people close to you over the last month?	☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite ☐ Very ☐ Unknown
27. Overall how satisfied are you with the health care services you got 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
28. Do you think you need more health care services than you received?	☐ No ☐ Yes ☐ Unknown
29. 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

30. 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
31. 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
32. 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
33. In the past week, has your ability to taste or smell changed from pre-injury?	☐ No ☐ Yes ☐ Unknown

34. In the past week, 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

35. 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:

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

36. 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:

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).

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

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

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 - Logstical
- 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

Follow-up Pre-Assessment Questions:

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

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:

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

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

☐ N/A Worked in last 7 days
☐ Still in hospital
☐ Unknown
Other, please specify:

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

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?
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)

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
N/A, have not worked in the past 4 weeks (28 days) *
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?
No
Yes
Refused
N/A did not miss part of an entire work day due to physical or mental health
N/A, have not worked in the past 4 weeks (28 days) *
Unknown
*(i.e. not in work force - retired, student, homemaker)

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

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)
N/A have not worked in the past 4 weeks (28 days)*
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)
N/A have not worked in the past 4 weeks (28 days)*
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
No
Yes
N/A
Unknown

2. Part-time or reduced hours
No
Yes
N/A
Unknown

3. Modified schedule
No

	☐ Yes ☐ N/A ☐ Unknown
4. Transfer to a different job with different tasks	☐ No ☐ Yes ☐ N/A ☐ Unknown
5. Equipment/assistive technology to help perform the job	☐ No ☐ Yes ☐ N/A ☐ Unknown
6. Job coaching/mentor to be able to do job	☐ No ☐ Yes ☐ N/A ☐ Unknown
17. Did you attend school in the last week? (choose one)	☐ No ☐ Yes ☐ N/A not a student pre-injury ☐ Unknown
18. What is the main reason you did not attend school in the past week? (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 ☐ 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 * 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: ☐ No ☐ Yes ☐ Unknown
20. Were you given contact information for where to follow up with symptoms from your injury? (choose one)	☐ No ☐ Yes ☐ Unknown
21. Did anyone from the hospital call you to follow up with you about your injury? (choose one)	☐ No ☐ Yes ☐ Unknown
22. 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)*	Did it help?
☐ General practitioner (primary care)	☐ No ☐ Yes ☐ Unknown
☐ TBI/Concussion Clinic	☐ No ☐ Yes ☐ Unknown
☐ Neurologist	☐ No ☐ Yes ☐ Unknown
☐ Physiatrist	☐ No ☐ Yes ☐ Unknown
☐ Chiropractor	☐ No ☐ Yes ☐ Unknown
☐ Psychiatrist	☐ No

	☐ Yes ☐ Unknown
☐ Psychologist, psychological services	☐ No ☐ Yes ☐ Unknown
☐ Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.)	☐ No ☐ Yes ☐ Unknown
☐ Other Other, please specify	☐ No ☐ Yes ☐ Unknown

23. Have you seen any healthcare provider since your last study visit for any peripheral injuries (e.g. fractured limbs, eye injuries, etc.)?
☐ No
☐ Yes
☐ Unknown

Type of clinician care: *(If yes, check all that apply)*	Did it help?
☐ General practitioner (primary care)	☐ No ☐ Yes ☐ Unknown
☐ Cardiologist	☐ No ☐ Yes ☐ Unknown
☐ Orthopedics	☐ No ☐ Yes ☐ Unknown
☐ Oral and maxillofacial Surgery	☐ No ☐ Yes ☐ Unknown
☐ Plastic Surgery	☐ No ☐ Yes ☐ Unknown
☐ ENT	☐ No ☐ Yes ☐ Unknown
☐ Other Other, please specify:	☐ 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?

	☐ No ☐ Yes
Physical therapy	☐ 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
- Unknown

Peer mentoring
- No
- Yes
- Unknown

Social work/Case management
- No
- Yes
- Unknown

Independent living training
- No
- Yes
- Unknown

Other
- No
- Yes
- Unknown

Other, please specify:

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

26. Were you treated as an **outpatient** for problems related to your brain injury?
- Yes
- No

How long did you receive treatment?
- < 2 weeks
- 2-4 weeks
- 5-8 weeks
- 9-12 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	☐ No ☐ Yes ☐ Unknown
Independent living training	☐ No ☐ Yes ☐ Unknown
Other	☐ No ☐ Yes ☐ Unknown Other, please specify:
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:

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

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

Type of therapy: (check all that apply)	Did it help?
Inpatient Rehabilitation	
☐ Physical Therapy	☐ No ☐ Yes ☐ Unknown
☐ Occupational Therapy	☐ No ☐ Yes ☐ Unknown
☐ Other	

Other, please specify:
☐ No ☐ Yes ☐ Unknown

Outpatient Rehabilitation

☐ Physical Therapy ☐ No ☐ Yes ☐ Unknown

☐ Occupational Therapy ☐ No ☐ Yes ☐ Unknown

☐ Other
Other, please specify:
☐ No ☐ Yes ☐ Unknown

29. Overall how satisfied are you with the availability of support from people close to you over the last 3 months?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite ☐ Very ☐ Unknown

30. Overall how satisfied are you with the health care services you got 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

31. Do you think you need more health care services than you received so far?
☐ No ☐ Yes ☐ Unknown

32. 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

33. 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

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?
☐ No ☐ Yes ☐ Unknown

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?
☐ No ☐ Yes ☐ Unknown

36. In the past week, has your ability to taste or smell changed from pre-injury?
☐ No ☐ Yes ☐ Unknown

37. 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

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

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

39. Who ***most often*** helps you with these tasks?

- ☐ Spouse/partner
- ☐ Child
- ☐ Other family member
- ☐ Friend
- ☐ Volunteer or other unpaid
- ☐ Home health care worker
- ☐ Employee of the place where you live
- ☐ Other paid
- ☐ Unknown
- ☐ 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

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”

- [ ] 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

48. 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

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

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

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-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 - Logstical
- 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

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
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

If yes:
- 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:

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

- 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:

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 Worked 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.

Other, please specify:

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

	☐ Technician ☐ Service worker ☐ Sales worker ☐ Administrative support worker ☐ Police officer, firefighter, corrections officer or other safety employee ☐ Active duty military ☐ Unknown
14. In the year since your injury, how many people did you personally supervise on your main job?	Click here for more information ☐ None ☐ Under 10 ☐ 10-99 ☐ 100-999 ☐ Over 1000 ☐ Refuse to answer ☐ N/A ☐ Unknown

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 (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 ◯ 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?	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)
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

	☐ N/A, have not worked in the past 4 weeks (28 days) * ☐ 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?	☐ No ☐ Yes ☐ Refused ☐ N/A did not miss an entire work day due to physical or mental health ☐ N/A, have not worked in the past 4 weeks (28 days) * ☐ Unknown *(i.e. not in work force - retired, student, homemaker)
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)	Number of hours worked Or: ○ Refused ○ N/A (i.e not in work force - retired, student, homemaker) ○ Unknown
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)	(range 0 -10) Or: ○ Refused to answer ○ N/A (i.e not in work force - retired, student, homemaker) ○ N/A have not worked in the past 4 weeks (28 days)* ○ Unknown *(worker pre and/or post injury)
18. Using the same 0 to 10 scale, how would you rate your overall performance during the past 4 weeks (28 days)?	(range 0-10) Or: ○ Refused to answer ○ N/A (i.e not in work force - retired, student, homemaker) ○ N/A have not worked in the past 4 weeks (28 days)* ○ Unknown *(worker pre and/or post injury)
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	☐ Yes ☐ No ☐ N/A ☐ Unknown
2. Part-time or reduced hours	☐ No ☐ Yes ☐ N/A ☐ Unknown
3. Modified schedule	☐ Yes ☐ No ☐ N/A ☐ Unknown
4. Transfer to a different job with different tasks	☐ No ☐ Yes ☐ N/A ☐ Unknown
5. Equipment/assistive technology to help perform the job	☐ No ☐ Yes ☐ N/A ☐ Unknown
6. Job coaching/mentor to be able to do job	☐ No ☐ Yes ☐ N/A ☐ Unknown
20. Did you attend school in the last week? (choose one)	☐ Yes ☐ No

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

- ☐ N/A not a student pre-injury
- ☐ Unknown
- ☐ 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)*	Did it help?
☐ General practitioner (primary care)	☐ No ☐ Yes ☐ Unknown
☐ TBI/Concussion Clinic	☐ No ☐ Yes ☐ Unknown
☐ Neurologist	☐ No ☐ Yes ☐ Unknown
☐ Physiatrist	☐ No ☐ Yes ☐ Unknown
☐ Chiropractor	☐ No ☐ Yes ☐ Unknown
☐ Psychiatrist	☐ No ☐ Yes ☐ Unknown
☐ Psychologist, psychological services	☐ No ☐ Yes ☐ Unknown
☐ Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.)	☐ No ☐ Yes ☐ Unknown
☐ Other Other, please specify	☐ 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

Unknown

Type of healthcare provider: *(If yes, check all that apply)*	Did it help?
General practitioner (primary care)	No / Yes / Unknown
Cardiologist	No / Yes / Unknown
Orthopedics	No / Yes / Unknown
Oral and maxillofacial Surgery	No / Yes / Unknown
Plastic Surgery	No / Yes / Unknown
ENT	No / Yes / Unknown
Other	
Other, please specify:	No / Yes / Unknown

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	No / Yes / Unknown
Long-Term Acute Care Hospital (LTACH)	No / Yes / Unknown
Inpatient Rehabilitation Facility (IRF)	No / Yes / Unknown
Skilled Nursing Facility	No / Yes / Unknown
Other	No / Yes / 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 ☐ Unknown
Peer mentoring	☐ No ☐ Yes ☐ Unknown
Social work/Case management	☐ No ☐ Yes ☐ Unknown
Independent living training	☐ No ☐ Yes ☐ Unknown
Other	☐ No ☐ Yes ☐ Unknown Other, please specify:

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)*	
	☐ No
Physical therapy	☐ 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
Peer mentoring	☐ Unknown ☐ No ☐ Yes
Social work/Case management	☐ Unknown ☐ No ☐ Yes
Independent living training	☐ Unknown ☐ No ☐ Yes
Other	☐ Unknown ☐ No ☐ Yes ☐ Unknown Other, please specify:

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

Type of therapy: (check all that apply)	Did it help?
Inpatient Rehabilitation	
☐ Physical Therapy	☐ No ☐ Yes ☐ Unknown
☐ Occupational Therapy	☐ No ☐ Yes ☐ Unknown
☐ Other	

Other, please specify:
- No
- Yes
- Unknown

Outpatient Rehabilitation

- Physical Therapy
  - No
  - Yes
  - Unknown
- Occupational Therapy
  - No
  - Yes
  - Unknown
- Other

Other, please specify:
- No
- Yes
- Unknown

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

- ☐ No (skip to Question #43)
- ☐ Yes
- ☐ Unknown (skip to Question #43)
- ☐ Refused

42. Who ***most often*** helps you with these tasks?

- ☐ Spouse/partner
- ☐ Child
- ☐ Other family member
- ☐ Friend
- ☐ Volunteer or other unpaid
- ☐ Home health care worker
- ☐ Employee of the place where you live
- ☐ Other paid
- ☐ Unknown
- ☐ Refused

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

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.'

- No
- Yes
- Unknown

49. 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 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?

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

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

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

When?
- 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?
- ☐ Refused

Self-pay (uninsured)
- ☐ No
- ☐ Yes
- ☐ Unknown

Insurance through a current or former employer (of this person or another family member)
- ☐ No
- ☐ Yes
- ☐ Unknown

Insurance purchased directly from an insurance company or on the health insurance exchange (this person or family member)
- ☐ No
- ☐ Yes
- ☐ Unknown

Medicare, for people 65 and older, or people with certain disabilities
- ☐ No
- ☐ Yes
- ☐ Unknown

Medicaid, Medical Assistance, 'the State' or any kind of government-assistance plan for those with low incomes or a disability
- ☐ No
- ☐ Yes
- ☐ Unknown

Medicaid Pending
- ☐ No
- ☐ Yes
- ☐ Unknown

TRICARE, VA or other military health care
- ☐ No
- ☐ Yes
- ☐ Unknown

Any other type of health insurance or health coverage plan
- ☐ No
- ☐ Yes
- ☐ Unknown

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?

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?
- ☐ Unknown
- ☐ 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 or more ☐ Refused to answer ☐ 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 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
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

81

☐ Refused to answer
☐ Unknown

CAP 2Wk

Patient Identification Information

Date | Start Time | Stop Time | Time Spent

Form Used
- Form A
- Form B

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 - Logstical
- 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

TOTART Attention Subtest (TAS)

A. Count forward from 1 to 20
- 2- Correct
- 0- 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).

Number of Hits (correct targets identified)

Number of Omissions (incorrect targets identified)

CTD Vigilance Score = Hits (correct targets identified) X2 – 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

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 - Logstical
- 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

- [ ] 3 - Intelligible Verbalization *
- [ ] 2 - Vocalization/Oral Movement
- [ ] 1 - Oral Reflexive Movement
- [ ] 0 - None

COMMUNICATION SCALE

- [ ] 2 - Functional, Accurate †
- [ ] 1 - Non-Functional, Intentional *
- [ ] 0 - None

AROUSAL SCALE

- [ ] 3 - Attention
- [ ] 2 - Eye Opening w/o Stimulation
- [ ] 1 - Eye Opening with Stimulation
- [ ] 0 - Unarousable

TOTAL SCORE

TMT WAIS RAVLT NIH 2Wk

Patient Identification Information

TRAIL MAKING TEST (TMT)

TMT 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 - Logstical
- 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

TMT Completion Code Other

Confounding Issues

Date	Start Time	Stop Time	Time Spent

Hand Used
- Dominant
- Non-Dominant

	Trail Making Part A	**Trail Making Part B**
Time (in secs):		

WAIS IV

WAIS 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 - Logstical
- 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

WAIS Completion Code Other

Confounding Issues

Date	Start Time	Stop Time	Time Spent

Symbol Search Subset

Total correct (raw):

Total incorrect (raw):

Total Raw Score:

Coding Subset

Total correct (raw):

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 - Logstical
- [ ] 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

RAVLT Completion Code Other

Confounding Issues

Date

RAVLT	Start Time	Stop Time	Time Spent

20 Minute Delay RAVLT	Start Time	Stop Time	Time Spent

# of Correct Responses

Principal List Recall Trial 1	
Principal List Recall Trial 2	
Principal List Recall Trial 3	
Principal List Recall Trial 4	
Principal List Recall Trial 5	
Interference List Recall Trial 1	
Principal List Recall Trial 6	
20 Minute Delay Principal List Recall Trial 7	

NIH Toolbox Cognitive Battery

NIH 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 - Logstical
- ☐ 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

NIH Completion Code Other

NIH Confounding Issues

Date	Start Time	Stop Time	Time Spent

BTACT 6Mo

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
- 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 - Logstical
- 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

Word List Recall - Immediate & Delayed
Total number of Trial 1 correct responses — range 0-15
Total number of 20 minute delay recall correct responses

Digits Backward
Score — range 0,2-8

Category Fluency
Total number unique
Total repetitions
Total intrusions

Stop and Go Task Accuracy
Normal baseline score — range 0-20
Reverse baseline score — range 0-20
Experimental Score — range 0-32

Number Series
Total number of items correct — range 0-5

30 Seconds and Counting Task
Last number reached
Total number of errors

Total number of digits produced		100 - (number reached + number errors)	90

RPQ 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
- 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 - Logstical
- 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

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

	☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Nausea and/or vomiting	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Noise sensitivity (easily upset by loud noise)	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Sleep disturbance	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Fatigue, tiring more easily	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Being irritable, easily angered	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Feeling depressed or tearful	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Feeling frustrated or impatient	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Forgetfulness, poor memory	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Poor concentration	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Taking longer to think	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Blurred vision	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem

Light sensitivity (easily upset by bright light)	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Double vision	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem
Restlessness	☐ 0-Not experienced at all ☐ 1- No more of a problem ☐ 2- A mild problem ☐ 3- A moderate problem ☐ 4- A severe problem

Scoring (Coming soon)

RPQ-3

RPQ-13

PROMIS-PAIN 2Wk

Patient Identification Information

Date	Start Time	Stop Time	Time Spent

Test Completion Code

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

ISI 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
- 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 - Logstical
- 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

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).

1. Difficulty falling asleep
   - 0 None
   - 1 Mild
   - 2 Moderate
   - 3 Severe
   - 4 Very Severe
2. Difficulty staying asleep
   - 0 None
   - 1 Mild
   - 2 Moderate
   - 3 Severe
   - 4 Very Severe
3. Problems waking up too early
   - 0 None
   - 1 Mild

- [ ] 2 Moderate
- [ ] 3 Severe
- [ ] 4 Very Severe

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

Your Total Score = _____

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

Patient Identification Information

Date	Start Time	Stop Time	Time Spent

Test Completion Code

Test Completion Codes

Completion Code Other

Confounding Issues

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?
   - 1. Not at all
   - 2. Slightly
   - 3. Moderately
   - 4. Quite
   - 5. Very
2. Overall, how satisfied are you with how your brain is working, in terms of your concentration, memory, thinking?
   - 1. Not at all
   - 2. Slightly
   - 3. Moderately
   - 4. Quite
   - 5. Very
3. Overall, how satisfied are you with your feelings and emotions?
   - 1. Not at all
   - 2. Slightly
   - 3. Moderately
   - 4. Quite
   - 5. Very
4. Overall, how satisfied are you with your ability to carry out day to day activities?
   - 1. Not at all
   - 2. Slightly
   - 3. Moderately
   - 4. Quite
   - 5. Very
5. Overall, how satisfied are you with your personal and social life?
   - 1. Not at all
   - 2. Slightly
   - 3. Moderately
   - 4. Quite
   - 5. Very
6. Overall, how satisfied are you with your current situation and future prospects?
   - 1. Not at all
   - 2. Slightly
   - 3. Moderately
   - 4. Quite
   - 5. Very

QoLIBRI-OS Total Score

MPAI4-M2PI 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
- 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 - Logstical
- 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)

- [ ] 0-Independent; living without supervision or concern from others
- [ ] 1-Living without supervision but others have concerns about safety or managing responsibilities
- [ ] 2-Requires a little assistance or supervision from others (5-24% of the time)
- [ ] 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)

6. *Transportation
- [ ] 0- Independent in all modes of transportation including independent ability to operate a personal motor vehicle
- [ ] 1- Independent in all modes of transportation, but others have concerns about safety
- [ ] 2- Requires a little assistance or supervision from others (5-24% of the time); cannot drive
- [ ] 3- Requires moderate assistance or supervision from others (25-75% of the time); cannot drive
- [ ] 4- Requires extensive assistance or supervision from others (more than 75% of the time); cannot drive

7A. *Paid Employment: Rate either item 7A or 7B to reflect the primary desired social role. Do not rate both. Rate 7A if the primary social role is paid employment. If another social role is primary, rate only 7B. For both 7A and 7B, “support” means special help from another person with responsibilities (such as, a job coach or shadow, tutor, helper) or reduced responsibilities. Modifications to the physical environment that facilitate employment are not considered as support.
- [ ] 0- Full-time (more than 30 hrs/wk) without support
- [ ] 1- Part-time (3 to 30 hrs/ wk) without support
- [ ] 2- Full-time or part-time with support
- [ ] 3- Sheltered work
- [ ] 4- Unemployed; employed less than 3 hours per week

7B. *Other employment: Involved in constructive, role-appropriate activity other than paid employment. Check only one to indicate primary desired social role: Childrearing/care-giving Homemaker, no childrearing or care-giving Student Volunteer Retired (Check retired only if over age 60; if unemployed, retired as disabled and under age 60, indicate “Unemployed” for item 7A.
- [ ] 0- Full-time (more than 30 hrs/wk) without support; full-time course load for students
- [ ] 1- Part-time (3 to 30 hrs/ wk) without support
- [ ] 2- Full-time or part-time with support
- [ ] 3- Activities in a supervised environment other than a sheltered workshop
- [ ] 4- Inactive; involved in role-appropriate activities less than 3 hours per week

Check only one to indicate primary desired social role:
- [ ] Childrearing/care-giving
- [ ] Homemaker, no childrearing or care-giving
- [ ] Student
- [ ] Volunteer
- [ ] Retired

8. Managing money and finances: Shopping, keeping a check book or other bank account, managing personal income and investments
- [ ] 0- Independent, manages money without supervision or concern from others
- [ ] 1- Manages money independently but others have concerns
- [ ] 2- Requires mild assistance or supervision from others (5-24% of the time)
- [ ] 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)

Scoring

Raw Score

Coming soon

SWLS 2Wk

Patient Identification Information

Date of test | 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
- 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 - Logstical
- 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

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

3. I am satisfied with my life.	☐ 4- Neither Agree nor Disagree ☐ 5- Slightly Agree ☐ 6- Agree ☐ 7- Strongly Agree ☐ 1- Strongly Disagree ☐ 2- Disagree ☐ 3- Slightly Disagree ☐ 4- Neither Agree nor Disagree ☐ 5- Slightly Agree ☐ 6- Agree ☐ 7- Strongly Agree
4. So far I have gotten the important things I want in life.	☐ 1- Strongly Disagree ☐ 2- Disagree ☐ 3- Slightly Disagree ☐ 4- Neither Agree nor Disagree ☐ 5- Slightly Agree ☐ 6- Agree ☐ 7- Strongly Agree
5. If I could live my life over, I would change almost nothing.	☐ 1- Strongly Disagree ☐ 2- Disagree ☐ 3- Slightly Disagree ☐ 4- Neither Agree nor Disagree ☐ 5- Slightly Agree ☐ 6- Agree ☐ 7- Strongly Agree
SWLS Total Score	

SF-12 2Wk

Patient Identification Information

Date of test | Start Time | Stop Time | Time Spent

Test administered in Spanish?

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 - Logstical
- 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

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,

	Limited A Little ☐ 3 - No, Not Limited At All
3. Climbing SEVERAL flights of stairs:	☐ 1 - Yes, Limited A Lot ☐ 2 - Yes, Limited A Little ☐ 3 - No, Not Limited At All
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. ACCOMPLISHED LESS than you would like:	☐ 1 - Yes ☐ 2 - No
5. Were limited in the KIND of work or other activities:	☐ 1 - Yes ☐ 2 - No
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. ACCOMPLISHED LESS than you would like:	☐ 1 - Yes ☐ 2 - No
7. Didn't do work or other activities as CAREFULLY as usual:	☐ 1 - Yes ☐ 2 - No
8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work the home and housework)?	☐ 1 - Not At All ☐ 2 - A Little Bit ☐ 3 - Moderately ☐ 4 - Quite A Bit ☐ 5 - Extremely
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?	☐ 1 - All of the Time ☐ 2 - Most of the Time ☐ 3 - A Good Bit of the Time ☐ 4 - Some of the Time ☐ 5 - A Little of the Time ☐ 6 - None of the Time
10. Did you have a lot of energy?	☐ 1 - All of

	the Time ☐ 2 - Most of the Time ☐ 3 - A Good Bit of the Time ☐ 4 - Some of the Time ☐ 5 - A Little of the Time ☐ 6 - None of the Time
11. Have you felt downhearted and blue?	☐ 1 - All of the Time ☐ 2 - Most of the Time ☐ 3 - A Good Bit of the Time ☐ 4 - Some of the Time ☐ 5 - A Little of the Time ☐ 6 - None of the Time
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.)?	☐ 1 - All of the Time ☐ 2 - Most of the Time ☐ 3 - A Good Bit of the Time ☐ 4 - Some of the Time ☐ 5 - A Little of the Time ☐ 6 - None of the Time
SF-12 Total Score:	

SF-12 v2 2wk

Patient Identification Information

Date of test | Start Time | Stop Time | Time Spent

Test administered in Spanish?

SF12 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

SF12 Completion Code Other

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

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

- 2 - Yes, Limited A Little
- 3 - No, Not Limited At All

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

- [ ] 4-A little of the time
- [ ] 5-None of the time

b. Did you have a lot of energy?

- [ ] 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

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

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

PCL-5 2Wk

Patient Identification Information

Date of test | 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
- 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 - Logstical
- 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

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 <u>in the past month</u>.

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

bit
4 Extremely

3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

4. Feeling very upset when something reminded you of the stressful experience?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

6. Avoiding memories, thoughts, or feelings related to the stressful experience?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

8. Trouble remembering important parts of the stressful experience?
0 Not at all
1 A little bit
2 Moderately
3 Quite a

111

bit
4 Extremely

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)?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

10. Blaming yourself or someone else strongly for the stressful experience or what happened after it?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

12. Loss of interest in activities that you used to enjoy?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

13. Feeling distant or cut off from other people?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)?*
0 Not at all
1 A little bit
2 Moderately
3 Quite a

112

bit
4 Extremely

15. Irritable behavior, angry outbursts, or acting aggressively?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

16. Taking too many risks or doing things that cause you harm?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

17. Being “superalert” or watchful or on guard?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

18. Feeling jumpy or easily startled?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

19. Having difficulty concentrating?
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

20. Trouble falling or staying asleep?
0 Not at all
1 A little bit
2 Moderately
3 Quite a

bit113

4

Extremely

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
- 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 - Logstical
- 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

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

- [ ] 2- Moderately
- [ ] 3- Quite a bit
- [ ] 4- Extremely

4. Pains in heart or chest
- [ ] 0- Not at all
- [ ] 1- A little bit
- [ ] 2- Moderately
- [ ] 3- Quite a bit
- [ ] 4- Extremely

5. Feeling lonely
- [ ] 0- Not at all
- [ ] 1- A little bit
- [ ] 2- Moderately
- [ ] 3- Quite a bit
- [ ] 4- Extremely

6. Feeling tense or keyed up
- [ ] 0- Not at all
- [ ] 1- A little bit
- [ ] 2- Moderately
- [ ] 3- Quite a bit
- [ ] 4- Extremely

7. Nausea or upset stomach
- [ ] 0- Not at all
- [ ] 1- A little bit
- [ ] 2- Moderately
- [ ] 3- Quite a bit
- [ ] 4- Extremely

8. Feeling blue
- [ ] 0- Not at all
- [ ] 1- A little bit
- [ ] 2- Moderately
- [ ] 3- Quite a bit
- [ ] 4- Extremely

9. Suddenly scared for no reason
- [ ] 0- Not at all
- [ ] 1- A little bit
- [ ] 2- Moderately
- [ ] 3- Quite a bit
- [ ] 4- Extremely

10. Trouble getting your breath
- [ ] 0- Not at all
- [ ] 1- A little bit
- [ ] 2- Moderately
- [ ] 3- Quite a bit
- [ ] 4- Extremely

11. Feelings of worthlessness
- [ ] 0- Not at all
- [ ] 1- A little bit
- [ ] 2- Moderately
- [ ] 3- Quite a bit
- [ ] 4- Extremely

12. Spells or terror or panic
- [ ] 0- Not at all
- [ ] 1- A little bit
- [ ] 2- Moderately
- [ ] 3- Quite a bit
- [ ] 4- Extremely

13. Numbness or tingling in parts of your body
- [ ] 0- Not at all
- [ ] 1- A little bit
- [ ] 2- Moderately
- [ ] 3- Quite a bit
- [ ] 4- Extremely

14. Feeling hopeless about the future
- [ ] 0- Not at all
- [ ] 1- A little bit
- [ ] 2- Moderately
- [ ] 3- Quite a bit
- [ ] 4- Extremely

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

	Raw Score	T Score (coming soon)
Somatization		
Depression		
Anxiety		
GSI		

PHQ-9 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
- 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 - Logstical
- 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

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

	☐ 2 More than half the days ☐ 3 Nearly every day
5. Poor appetite or overeating	☐ 0 Not at all ☐ 1 Several days ☐ 2 More than half the days ☐ 3 Nearly every day
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐ 0 Not at all ☐ 1 Several days ☐ 2 More than half the days ☐ 3 Nearly every day
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0 Not at all ☐ 1 Several days ☐ 2 More than half the days ☐ 3 Nearly every day
8. 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	☐ 0 Not at all ☐ 1 Several days ☐ 2 More than half the days ☐ 3 Nearly every day
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0 Not at all ☐ 1 Several days ☐ 2 More than half the days ☐ 3 Nearly every day
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?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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

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
- 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
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- 2.5 Not completed - Illness
- 2.6 Not completed - Logstical
- 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

Suicidal Ideation

	Lifetime	*Recent*
1. Wish to be Dead	Yes / No	Yes / No
If yes, describe:		
2. Non-Specific Active Suicidal Thoughts	Yes / No	Yes / No
If yes, describe:		
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act	Yes / No	Yes / No
If yes, describe:		
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan	Yes / No	Yes / No
If yes, describe:		
5. Active Suicidal Ideation with Specific Plan and Intent	Yes / No	Yes / No
If yes, describe:		

Intensity of Ideation

Most Severe Ideation:	*Lifetime*	*Recent*
	1 Least Severe	1 Least Severe
	2	2
	3	3
	4	4
	5 Most Severe	5 Most Severe
	Description	Description

Frequency		
	☐ Less than once a week	☐ Less than once a week
	☐ Once a week	☐ Once a week
	☐ 2-5 times a week	☐ 2-5 times a week
	☐ Daily or almost daily	☐ Daily or almost daily
	☐ Many times each day	☐ Many times each day
Duration		
	☐ Fleeting	☐ Fleeting
	☐ Some of the time	☐ Some of the time
	☐ A lot of the time	☐ A lot of the time
	☐ Most of the day	☐ Most of the day
	☐ Persistent	☐ Persistent
Controllability		
	☐ Easily able to control thoughts	☐ Easily able to control thoughts
	☐ Can control thoughts with little difficulty	☐ Can control thoughts with little difficulty
	☐ Can control thoughts with some difficulty	☐ Can control thoughts with some difficulty
	☐ Can control thoughts with a lot of difficulty	☐ Can control thoughts with a lot of difficulty
	☐ Unable to control thoughts	☐ Unable to control thoughts
	☐ Does not attempt to control thoughts	☐ Does not attempt to control thoughts
Deterrents		
	☐ Deterrents definitely stopped attempts	☐ Deterrents definitely stopped attempts
	☐ Deterrents probably stopped attempts	☐ Deterrents probably stopped attempts
	☐ Uncertain that deterrents stopped attempts	☐ Uncertain that deterrents stopped attempts
	☐ Deterrents most likely did not stop attempts	☐ Deterrents most likely did not stop attempts
	☐ Deterrents definitely did not stop attempts	☐ Deterrents definitely did not stop attempts
	☐ Does not apply	☐ Does not apply
Reasons for Ideation		
	☐ Completely to get attention, revenge or reaction	☐ Completely to get attention, revenge or reaction
	☐ Mostly to get attention, revenge or reaction	☐ Mostly to get attention, revenge or reaction
	☐ Equally to get attention and to stop/end the pain	☐ Equally to get attention and to stop/end the pain
	☐ Mostly to end or stop the pain	☐ Mostly to end or stop the pain
	☐ Completely to stop or end the pain	☐ Completely to stop or end the pain
	☐ Does not apply	☐ Does not apply

Suicidal Behavior

Actual Attempt	***Lifetime***	***Recent***
	☐ Yes	☐ Yes
	☐ No	☐ No
Total # of Attempts		
Non-Suicidal Self-Injurious Behavior	☐ Yes	☐ Yes
	☐ No	☐ No
If yes, describe:		
Interrupted Attempt		
	☐ Yes	☐ Yes
	☐ No	☐ No
If yes, describe:		
Total # of Interrupted Attempts		
Aborted Attempt		
	☐ Yes	☐ Yes
	☐ No	☐ No
If yes, describe:		
Total # of Aborted Attempts		
Preparatory Acts or Behavior		
	☐ Yes	☐ Yes
	☐ No	☐ No
If yes, describe:		
Suicidal Behavior Present		
	☐ Yes	☐ Yes
	☐ No	☐ No

Actual Lethality/Medical Damage	***Most Recent Attempt***	***Most Lethal Attempt***	***Initial Attempt***
	☐ No physical damage (or very minor)	☐ No physical damage (or very minor)	☐ No physical damage (or very minor)
	☐ Minor physical damage	☐ Minor physical damage	☐ Minor physical damage
	☐ Moderate physical damage	☐ Moderate physical damage	☐ Moderate physical damage
	☐ Moderately severe physical	☐ Moderately severe physical	☐ Moderately severe physical damage

	damage ☐ Severe physical damage ☐ Death	damage ☐ Severe physical damage ☐ Death	☐ Severe physical damage ☐ Death
Potential Lethality	☐ Not likely to result in injury ☐ Likely to result in injury but not death ☐ Likely to result in death	☐ Not likely to result in injury ☐ Likely to result in injury but not death ☐ Likely to result in death	☐ Not likely to result in injury ☐ Likely to result in injury but not death ☐ Likely to result in death

Adverse Events

Patient Identification Information

Start Date Time

End Date Time

Severity

- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Life-threatening/Disabling
- ☐ Fatal/Death

Describe Event

During which procedure did the adverse event occur?

- ☐ 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