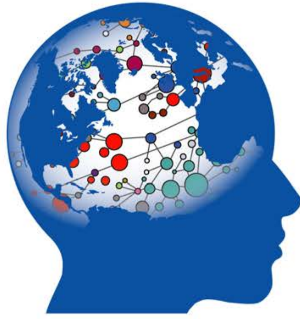


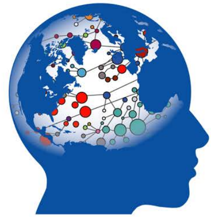
TRACK-TBI LONG

Transforming Research and Clinical Knowledge in Traumatic Brain Injury Longitudinal

In-Person

Case Report Forms

In Order of Test Administration



TRACK-TBI LONG
Transforming Research and Clinical Knowledge in Traumatic Brain Injury Longitudinal

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*The GOSE is administered to both the Participant and the Informant

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:____)

TRACK-TBI LONG: Pre-administration CRF

This form should be used at the discretion of study staff administering the follow-up assessment. The form is intended to contain information that will be referenced during the assessment and should be pulled from the subject's study record prior to the assessment. This will allow study staff to quickly refer to any specific time frames and study data that are relevant to the current assessment. Study staff do not need to use this form during the assessment if they have another preferred method of tracking the previous information collected from the participant. This form should be destroyed at the end of the assessment as the data is not new data and does not need to be retained. **This form should not be put in the participant's study binder as it contains PHI.**

Data points to review before administering the LONG battery (including PHI-DO NOT ADD TO SUBJECT BINDERS)

Date of Injury (month, year): _______________

- Forms involved and location of data point:
  - GOSE question 5
  - Participant Interview questions 4b, 6, 9a, 16, 17, 18
  - Informant Interview question 5a-5d, 6, 7, 11, 12, 13

Last study visit date (month, year):_______________

- Forms involved and location of data point:
  - Participant Interview questions 3a-3d, 8, 10a-d, 13, 29

Pre-injury marital status:___________________

- Forms involved and location of data point:
  - Participant Interview question 4a

Pre-injury living situation:___________________

- Forms involved and location of data point:
  - Participant Interview question 6

Work/student status pre-injury:___________________

- Forms involved and location of data point:
  - GOSE question 5
  - Participant Interview question 7a

Has the participant signed the consent to be contacted for future research at any point in the past? Y/N

- If no, administer the verbal consent to be contacted for future research ☐

To be used in conjunction with Patient Interview Examiner Interview Date: _________ UID: __________

New TBIs

Cause (car/moving vehicle accident; fall/struck by; Sports; Fight/Assault; Blast; Other)	Month/Year	Disposition (No Hospital; ED/Dr. Visit; Hospital Admit; ICU)	LOC (Yes; No; Unknown)	LOC Duration (< 30 min; 30 min to 24 hrs; >24 hrs)	Dazed/Memory Gap (Yes; No; Unknown)	Current difficulties? (If yes, details)

New Peripheral Injury:

Injury	Month/Year	Disposition (No Hospital; ED/Dr. Visit; Hospital Admit; ICU)	Current Problems? (If yes, details)

New Illnesses:

Illness (Heart Disease; Poisoning; Pneumonia; Infectious Disease; COVID; Mental Health; Other Nervous System; Illegal Drug Use; Cancer; Other)	Month/Year	Disposition (No Hospital; ED/Dr. Visit; Hospital Admit; ICU)	Current Problems? (If yes, details)

TRACK-TBI LONG In-person Participant Interview

Examiners: The interview, unless otherwise indicated, 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.

Date of study injury: **see Pre-admin CRF** **Date of last study visit:** **see Pre-admin CRF**

1.	Mode of Test Administration: ____ In-Person ____ Telephone
2.	Information was obtained from: ____ Subject alone ____ Subject with confirmation by significant other (Specify SO: ______________________) ____ Significant Other only (specify significant other and reason why not done with subject:____) ____ Primarily significant other with confirmation from subject (specify SO and reason why not done primarily with subject:________________________________)
3a1.	Since your study injury, have you been hospitalized or treated in an emergency room following an injury to your head or neck? ____ No ____ Yes, once ____ Yes, more than once ____ Unknown
3a2.	Since your study injury, have you injured your head or neck in a car accident or from crashing some other moving vehicle accident, e.g. car, truck, bicycle, van, all-terrain vehicle? ____ No ____ Yes, once ____ Yes, more than once ____ Unknown
3a3.	Since your study injury, have you injured your head or neck in a fall or from being hit by something? ____ No ____ Yes, once ____ Yes, more than once ____ Unknown

3a4.	Since your study injury, have you injured your head or neck in sports, e.g. football, soccer, skiing, blading, basketball, baseball, biking, horseback riding? _____ No _____ Yes, once _____ Yes, more than once _____ Unknown
3a5.	Since your study injury, have you injured your head or neck in a fight, assault, from being hit by someone or being shaken violently? _____ No _____ Yes, once _____ Yes, more than once _____ Unknown
3a6.	Since your study injury, have you been nearby when an explosion or blast occurred? _____ No _____ Yes, once _____ Yes, more than once _____ Unknown

	If participant answered yes to any question from 3a1-3a6, then fill out head injury details below:					
Cause	**Date**	**Disposition**	**LOC**	**LOC Duration**	**Dazed/Memory Gap**	**Are there current difficulties in your daily life due to this injury?**
□ Car/moving vehicle accident □ Fall/struck by □ Sport Injury □ Fight/Assault □ Blast □ Other		□ No Hospital □ ED □ Hospital Admit □ Hospital Admit with ICU	□ No □ Yes □ Unknown	□ <30 Min □ 30 min – 24 hrs □ >24 hrs	□ No □ Yes □ Unknown	□ No □ Yes □ Unknown
□ Car/moving vehicle accident □ Fall/struck by □ Sport Injury □ Fight/Assault □ Blast □ Other		□ No Hospital □ ED □ Hospital Admit □ Hospital Admit with ICU	□ No □ Yes □ Unknown	□ <30 Min □ 30 min – 24 hrs □ >24 hrs	□ No □ Yes □ Unknown	□ No □ Yes □ Unknown
□ Car/moving vehicle accident □ Fall/struck by □ Sport Injury □ Fight/Assault □ Blast □ Other		□ No Hospital □ ED □ Hospital Admit □ Hospital Admit with ICU	□ No □ Yes □ Unknown	□ <30 Min □ 30 min – 24 hrs □ >24 hrs	□ No □ Yes □ Unknown	□ No □ Yes □ Unknown
□ Car/moving vehicle accident □ Fall/struck by □ Sport Injury □ Fight/Assault □ Blast □ Other		□ No Hospital □ ED □ Hospital Admit □ Hospital Admit with ICU	□ No □ Yes □ Unknown	□ <30 Min □ 30 min – 24 hrs □ >24 hrs	□ No □ Yes □ Unknown	□ No □ Yes □ Unknown

3b1.	Did you sustain any peripheral injuries (injuries to other parts of the body) since your study injury? ____ No (skip to 3c) ____ Yes one time ____ Yes, more than one time ____ Unknown (skip to 3c)
3b2.	Were you admitted to the ICU for any of the new peripheral injuries? ____ No (go to #3b3) ____ Yes, once (go to #3b5) ____ Yes, more than one time (go to #3b5) ____ Unknown (go to #3b3)
3b3.	Were you admitted to the hospital but not to the ICU for any of the new peripheral injuries? ____ No (go to #3b4) ____ Yes, once (go to #3b5) ____ Yes, more than one time (go to #3b5) ____ Unknown (go to #3b5)
3b4.	Were you treated and released from the ED, Dr. office or other outpatient service for any of your new peripheral injuries? ____ No ____ Yes, once ____ Yes, more than one time ____ Unknown
3b5.	Are there current difficulties in your daily life due to the new peripheral injury(ies)? ____ No ____ Yes; specify:___________________________ ____ Unknown; explain:_____________________
3c.	Have you experienced any other new medical issues or illnesses since your study injury that required hospitalization for any reason or caused major disruption in functioning and/or continues to cause ongoing problems? (e.g., heart disease, accidental poisoning, pneumonia, infectious disease, other nervous system disease, mental health difficulties [e.g., depression, anxiety, etc.], illegal drug use, etc.) ____ No ____ Yes; Specify: ____ ____ Unknown; explain: ____

4a.	Current Marital Status (**choose one**) ___ Never married ___ Married ___ Domestic Partnership ___ Divorced ___ Separated ___ Widowed ___ Unknown
4b.	If there is a change in marital status since your study injury, is this related to your study injury? ___ No ___ Yes: comment____ ___ N/A no change in marital status since the study injury ___ Unknown
5.	Living situation/residence. 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 (irrespective of injury, not due to health, includes financial reasons related to the study injury) ___ 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
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 problem unrelated to study injury ___ Limitations resulting from a new injury reported in Q#3 of this interview

	___ Financial problems related to the study injury ___ Financial problems unrelated to the study injury ___ Other:______________________________ ___ N/A – no change ___ Unknown
7a.	What is your current employment status? (**choose one**) ___ Working now ___ Disabled, permanently or temporarily (e.g., working before the injury, not working now due to health and no longer has a job to return to) ___ Only temporarily laid off, sick leave, or maternity leave (e.g., working before the injury, not working now due to health but still has a job to return to) ___ Keeping house ___ Looking for work, unemployed (e.g., able to work but currently unemployed); employed but not working (e.g., those who are employed but for some reason (unrelated to health) are not working) ___ Student ___ Retired ___ Other, specify _____________________________________ ___ Not applicable, still in hospital ___ Unknown
7b.	If you are not currently working, why not? (**choose one**) ___ 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 currently working ___ N/A, was not a worker before injury and am not a worker now ___ Unknown
8a.	Years of Education completed (as of today) _________ ____ Unknown
8b.	Highest Level of Education Completed ___ Never attended/Kindergarten Only ___ 1st grade ___ 2nd grade ___ 3rd grade

	___ 4th grade ___ 5th grade ___ 6th grade ___ 7th grade ___ 8th grade ___ 9th grade ___ 10th grade ___ 11th grade ___ 12th grade, no diploma ___ GED or equivalent ___ High school graduate ___ Some college, no degree ___ Associate degree occupational, technical, or vocational program ___ Associate degree academic program ___ Bachelor’s degree (e.g., BA, AB, BS, BBA) ___ Master’s degree (e.g., MA, MS, Meng, Med, MBA) ___ Professional school degree (e.g. MD, DDS, DVM, JD) ___ Doctoral degree (e.g., PhD, EdD) ___ Unknown
8c.	[Years of Education (automatically derived from Level of Edu on QuesGen)]

9.	**[Skip question for Trauma Controls and Friend Controls] Follow Up Care** For TBI participants: Have you seen any healthcare provider (e.g., doctor, psychologist, rehabilitation therapist) since your last study visit for your traumatic brain injury (your study brain injury)? ___ No ___ Yes ___ Unknown How long did you receive outpatient treatment? ___ Active outpatient rehab ongoing ___ Annual check up ___ Unknown ___ N/A

10a Gardner Parkinsonism Screening Questions								
				If Yes,				
				Symptom present before study injury?		Course of symptom over the past year?		
Question	**Yes**	**No**	**Do not Know**	**Yes**	**No**	**Getting Better**	**Getting Worse**	**About the same**
1. Do you have trouble arising from a chair?								
2. Is your hand-writing smaller than it once was?								
3. Do people tell you that your voice is softer that it once was?								
4. Is your balance, when walking, poor?								
5. Do your feet suddenly seem to freeze in door-ways?								
6. Does your face seem less expressive than it used to?								
7. Do your arms and legs shake?								
8. Do you have trouble buttoning buttons?								
9. Do you shuffle your feet and take tiny steps when you walk?								
10. Do you feel you move more slowly or stiffly than other people your age?								
11. Do you walk with a stooped posture?								
12. Have you noticed that you don't swing your arms when you walk as much as you used to?								

10b.	Have you been told by a healthcare professional that you have any of the following? *(Check all that apply)* __ Parkinson's Disease __ Mild Cognitive Impairment *(NOTE: this is a medical diagnosis that is often a precursor to dementia) [MCI is defined by PROGRESSIVELY WORSENING deficits in memory or thinking that do not yet significantly impact daily functioning]* __ Alzheimer's Disease __ Other dementia __ Lou Gehrig's Disease/ALS __ No __ Unknown
	"Now I would like to ask you how you think you are doing in 4 general areas, compared to how you were doing since your last assessment with us. For each area I am interested in whether you think you are doing overall BETTER, WORSE, or ABOUT THE SAME since your last study visit."
11a.	In the area of taking care of yourself and your basic needs at home, like eating, using the bathroom, getting bathed and dressed and ready for the day, are you doing MUCH BETTER, BETTER, ABOUT THE SAME, WORSE or MUCH WORSE since your last study visit? ___ Much Better ___ Better ___ About the same ___ Worse ___ Much Worse ___ Unknown
11b.	In the area of physical function, moving around and getting around either on foot or in a wheelchair, getting up and down stairs, and getting in and out of bed, are you doing MUCH BETTER, BETTER, ABOUT THE SAME, WORSE or MUCH WORSE since your last study visit? ___ Much Better ___ Better ___ About the same ___ Worse ___ Much Worse ___ Unknown

11c.	In the area of mental function, like remembering things, communicating with others, learning a new task (for example, learning how to get to a new place), concentrating on doing something, and solving everyday problems, are you doing MUCH BETTER, BETTER, ABOUT THE SAME, WORSE or MUCH WORSE since your last study visit? ___ Much Better ___ Better ___ About the same ___ Worse ___ Much Worse ___ Unknown
11d.	In the area of emotional function, like managing your mood, getting along with others, and dealing with everyday stress, are you doing MUCH BETTER, BETTER, ABOUT THE SAME, WORSE or MUCH WORSE since your last study visit? ___ Much Better ___ Better ___ About the same ___ Worse ___ Much Worse ___ Unknown
12.	**REM Sleep Behavior Disorder Screening Questionnaire**: Next are some questions asking about sleep patterns, dreams and movements during sleep. Please rate the following by saying yes or no.
12a.	I sometimes have very vivid dreams ___ Yes ___ No ___ Unable to answer
12b.	My dreams often have aggressive or action-packed content ___ Yes ___ No ___ Unable to answer
12c.	The movement of my body at night often corresponds to my dreams ___ Yes ___ No ___ Unable to answer

12d.	I know that I move my arms or legs in my sleep ___ Yes ___ No ___ Unable to answer
12e.	When this has happened, I have sometimes (almost) hurt my sleeping partner or myself ___ Yes ___ No ___ Unable to answer
	I experience or have experienced the following phenomena during my dreams:
12f1.	speaking, shouting, swearing, laughing loudly ___ Yes ___ No ___ Unable to answer
12f2.	sudden limb movements, "fights" ___ Yes ___ No ___ Unable to answer
12f3.	gestures, sequences of movements that are pointless during sleep, e.g. waving, saluting, shooing a fly away, falling out of bed ___ Yes ___ No ___ Unable to answer
12f4.	things that have fallen down around the bed, e.g. bedside lamp, book, glasses ___ Yes ___ No ___ Unable to answer
12g.	At times, I'm woken up by my own movements ___ Yes ___ No ___ Unable to answer
12h.	On waking up, I can usually remember the content of my dreams well ___ Yes ___ No ___ Unable to answer

12i.	My sleep is often disturbed ___ Yes ___ No ___ Unable to answer
12j.	I have/had a disease of the nervous system (check all that apply): __ Stroke __ Head Trauma (pt should select if enrolled in TRACK-TBI as TBI case) __ Parkinson's Disease __ Restless Leg Syndrome __ Narcolepsy __ Depression __ Epilepsy __ Inflammatory disease of the brain __ Post traumatic stress disorder __ Obstructive Sleep Apnea __ Other: ___________________
13.	**COVID-19 Questions**: "*Now I have some questions about the impact COVID-19 has had on your life and the lives of those close to you.*" Check all that apply (a-f). Data entry on separate form.
13a.	Did you or someone close to you become ill from possible or certain exposure to the coronavirus? __ It happened to me directly __ It happened to someone close to me __ Does not apply
13b.	Were you or was someone close to you hospitalized from exposure to the coronavirus? __ It happened to me directly __ It happened to someone close to me __ Does not apply
13c.	Did your job require possible exposure to coronavirus? Did the job of someone close to you require possible exposure to coronavirus? __ It happened to me directly __ It happened to someone close to me __ Does not apply
13d.	Did you or someone close to you lose their job or income due to the coronavirus pandemic? __ It happened to me directly __ It happened to someone close to me __ Does not apply

13e.	Was there an increase in responsibilities at home due to the coronavirus pandemic for you or someone close to you? __ It happened to me directly __ It happened to someone close to me __ Does not apply
13f.	Did you or someone close to you have difficulty getting food, medication, important medical procedures or other necessities due to the coronavirus pandemic? __ It happened to me directly __ It happened to someone close to me __ Does not apply
13g.	Over the past week, how much difficulty have you had getting the social support you need due to the coronavirus pandemic? __ No difficulty at all __ Very little difficulty __ Some difficulty __ A lot of difficulty __ Extreme Difficulty
13h.	Over the past week, how many hours a day are you exposed to coronavirus information (radio, TV, twitter, Facebook, Instagram, newspapers)? __ None at all __ Less than an hour __ About an hour __ One to two hours __ More than two hours
13i.	Over the past week, how much distress have you experienced related to the coronavirus? __ No distress __ Very little distress __ Some distress __ A lot of distress __ Extreme Distress
	Caregiver Time: The next question asks about the help you've needed since your last study visit.
14.	Do you think the amount of help you need has increased since your last study visit? ___ No ___ Yes ___ Unknown
	Epilepsy Screening: The next several questions ask about epilepsy and seizures.

15.	(To the administrator) Which of the following sources of information were queried? (**check all that apply**) ___ Research Participant ___ Caregiver ___ Medical Record
	Have you had or has anyone ever told you that you had any of the following?
15a.	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
15b.	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
15c.	Any other type of repeated unusual attacks or convulsions lasting about 5 minutes or less? ___ No ___ Yes ___ Unknown
16.	Has anyone ever told you that you have seizure(s) or epilepsy? ___ No ___ Yes ___ Unknown
	If 1 or more of questions 14a, 14b, 14c or 15 = yes then ask questions 16 – 21. If 14a – 15 are each = no then skip question 16 – 21 and go to question 22.
17.	Did the most recent seizure(s) occur later than 7 days after the date of the traumatic brain injury? ___ No ___ Yes ___ Unknown
18.	Did you have seizures or epilepsy prior to the traumatic brain injury? ___ No ___ Yes ___ Unknown
19.	Were you diagnosed with epilepsy, a seizure disorder, or a single seizure after the date of the traumatic brain injury diagnosis? ___ No (skip to Q21)

	___ Yes ___ Unknown
20.	Date of diagnosis: ______________________________
21.	Who gave this diagnosis? ___ Neurosurgeon ___ Neurologist ___ Pediatric Neurologist ___ Primary Care Physician ___ Pediatrician ___ Psychiatrist ___ Psychologist ___ Nurse Practitioner ___ Physiatrist ___ Other, specify:________________________
22.	Have you received medication for seizures or epilepsy? ___ No - never ___ Yes – Pre-injury only ___ Yes – Post injury but not currently ___ Yes – Currently ___ Unknown
23.	Do you currently use tobacco or vape? ___ No ___ Yes Respond to each N=No Y=Yes U=Unknown ______Filtered cigarettes; ______Non-filtered cigarettes; ______Low tar cigarettes; ______Cigars; ______Pipes; ______Chewing tobacco; ______E cigarettes; ______Other, specify:________________________

24.	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
25.	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 ___ Not applicable, have not had any alcohol since injury ___ Unknown
26.	How often do you have (if subject identifies as male, ask “five”; if subject identifies as female ask “four”) or more drinks on one occasion? ___ Never ___ Less than monthly ___ Monthly ___ Weekly ___ Daily or almost daily ___ Not applicable, have not had any alcohol since injury ___ Unknown
27a.	In the last month, did you use Marijuana? ___ No (If the answer is ‘YES” then ask, ‘Was Marijuana prescribed to you’) ___ Yes (Used Marijuana that was prescribed) ___ Yes (Used Marijuana that was NOT prescribed) (Note: if used both prescribed Marijuana and Marijuana that was not prescribed, code Marijuana as NOT prescribed) ___ Unknown

27b.	In the last month, did you use Cannabidiol (CBD) oil? ___ No (If the answer is 'YES" then ask, 'Was CBD oil prescribed to you') ___ Yes (Used CBD oil that was prescribed) ___ Yes (Used CBD oil that was NOT prescribed) (Note: if used both prescribed CBD oil and CBD oil that was not prescribed, code CBD oil as NOT prescribed) ___ Unknown
28.	In the last month, did you use any illicit or non-prescription drugs? 'We want to know about drugs like 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
29.	**Skip this question if question #28 = no (even if question #27a-b=yes)** 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) **Codes: N=No Y= Yes U= Unknown** ____a. Sedatives ____b. Tranquilizers or anti-anxiety drugs ____c. Painkillers ____d. Stimulants ____e. Cocaine or crack ____f. Hallucinogens ____g. Inhalants or solvents ____h. Heroin ____i. Synthetic drugs like "fake marijuana" and "bath salts" (street names keep changing but "fake marijuana" and "bath salts" have persisted in the vernacular) ____j. Any OTHER substances or medicines you have used to get high (Specify:____)

30	Since your last study visit 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
31.	The next question asks about using prescription pain relievers in any way a doctor did not direct you to use them. These would include drugs such as codeine, Vicodin, and others. Do not include over-the-counter pain relievers like Aspirin or Tylenol or Advil, only prescription pain relievers. When you answer this question, please think only about your use of the drug in any way a doctor did not direct you to use it, including: using it without a prescription of your own, using it in greater amounts, more often, or longer than you were told to take it, using it in any other way a doctor did not direct you to use it. In the past 12 months, have you ever, even once, used any prescription pain reliever in any way a doctor did not direct you to use it? ___ No ___ Yes ___ Unknown
32.	Is the study participant covered by any of the following types of health insurance? **N=No Y=Yes U=Unknown** ___ Self-pay (uninsured) ___ Insurance through a current or former employer (of this person or another family member) ___ Insurance purchased directly from an insurance company or on the health insurance exchange (this person or family member) ___ Medicare, for people 65 and older, or people with certain disabilities ___ Medicaid, Medical Assistance, ‘the State’ or any kind of government-assistance plan for those with low incomes or a disability ___ Medicaid Pending ___ TRICARE, VA or other military health care ___ Any other type of health insurance or health coverage plan ___ Refused

33.	During the last year, how much money did you receive from wages or salary, tips, commissions, or bonuses, or your own business or practice, before taxes and other deductions? ___ None ___ Less than $10,000 ___ $10,000 to $14,999 ___ $15,000 to $24,999 ___ $25,000 to $34,999 ___ $35,000 to $49,999 ___ $50,000 to $74,999 ___ $75,000 to $99,999 ___ $100,000 to $149,999 ___ $150,000 to $199,999 ___ $200,000 or more ___ Refused ___ Unknown

DATE ADMINISTERED:____________ SUBJECT ID:____________ START TIME:____________

Glasgow Outcome Scale—Extended (GOS-E)

CONSCIOUSNESS

1. Is the head injured person able to obey simple commands, or say any words?
1 ☐ No **(VS)** 2 ☐ Yes

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. Eye movements are not reliable evidence of meaningful responsiveness. Corroborate with nursing staff. Confirmation of VS requires full assessment as in the Royal College of Physician Guidelines.

INDEPENDENCE IN THE HOME

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

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

2b. Do they need frequent help or someone to be around at home most of the time?
1 ☐ No **(Upper SD)** 2 ☐ Yes **(Lower SD)**

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

2c. Was assistance at home essential before the injury? 1 ☐ No 2 ☐ Yes

INDEPENDENCE OUTSIDE THE HOME

3a. Are they able to shop without assistance? 1 ☐ No **(Upper SD)** 2 ☐ Yes

This includes being able to plan what to buy, take care of money themselves, and behave appropriately in public. They need not normally shop, but must be able to do so.

3b. Were they able to shop without assistance before the injury? 1 ☐ No 2 ☐ Yes

4a. Are they able to travel locally without assistance? 1 ☐ No **(Upper SD)** 2 ☐ Yes

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 without assistance before the injury? 1 ☐ No 2 ☐ Yes

WORK

5a. Are they currently able to work to their previous capacity? 1 ☐ No 2 ☐ Yes

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

5b. How restricted are they?
1 ☐ Reduced work capacity **(Upper MD)**
2 ☐ Able to work only in a sheltered workshop or non-competitive job or currently unable to work **(Lower MD)**

5c. Were they either working or seeking employment before the injury (answer 'yes') or were they doing neither (answer 'no')? 1 ☐ No 2 ☐ Yes

SOCIAL & LEISURE ACTIVITIES

6a. Are they able to resume regular social and leisure activities outside home? 1 ☐ No 2 ☐ Yes

They need not have resumed all their previous leisure activities, but should not be prevented by physical or mental impairment. If they have stopped the majority of activities because of loss of interest or motivation then this is also considered a disability.

6b. What is the extent of restriction on their social and leisure activities?
1 ☐ Participate a bit less: at least half as often as before injury **(Lower GR)**
2 ☐ Participate much less: less than half as often **(Upper MD)**
3 ☐ Unable to participate: rarely, if ever, take part **(Lower MD)**

6c. Did they engage in regular social and leisure activities outside home before the injury? 1 ☐ No 2 ☐ Yes

DATE ADMINISTERED:___________ SUBJECT ID:___________

FAMILY & FRIENDSHIPS

7a. Have there been psychological problems which have resulted in ongoing family disruption or disruption to friendships?

1 ☐ No 2 ☐ Yes

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?

1 ☐ Occasional - less than weekly **(Lower GR)**

2 ☐ Frequent - once a week or more, but tolerable **(Upper MD)**

3 ☐ Constant - daily and intolerable **(Lower MD)**

7c. Were there problems with family or friends before the injury? 1 ☐ No 2 ☐ Yes

If there were some problems before injury, but these have become markedly worse since injury then answer 'No' to Q7c.

RETURN TO NORMAL LIFE

8a. Are there any other current problems relating to the injury which affect daily life?

1 ☐ No **(Upper GR)** 2 ☐ Yes **(Lower GR)**

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

8b. Were similar problems present before the injury? 1 ☐ No 2 ☐ Yes

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

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.

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

GOS-E SCORE:

____

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use

Test Completion Code (circle one):

1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|

If 1.3 or 5.0 (Other) Please Specify: ____________________

END TIME:___________

TRACK-TBI: RAVLT Instructions

Instructions: After engaging the participant's attention, the examiner should say, *"I am going to read a list of words. Listen carefully, for when I stop you are to repeat back as many words as you can remember. It doesn't matter in what order you repeat them, just try to remember as many as you can."* The examiner then reads the words aloud with a one second interval between each of the 15 words. Immediately after the words are read, the participant recalls as many as possible, each recorded by the examiner.

Trial II - V

After the participant indicates that no more words can be recalled, the examiner should say, *"Now I am going to read the same words again, and once again when I stop I want you to tell me as many words as you can remember, including words you said the first time. It doesn't matter in what order you say them, just say as many words as you can remember, whether or not you said them before."* Immediately after the words are read, the participant recalls as many as possible, each recorded by the examiner. Be sure to emphasize that words that were recalled on previous trials should be included again on the current trial.

The first time a participant recalls a stimulus word it is counted as correct. If later, in the same trial, the same stimulus word is recalled, the second recall is a perseveration and not counted. If the participant recalls a word that was not on the list, this is considered an intrusion and not counted.

Repeat the preceding instructions for the remaining learning trials

Interference Trial

After trial V is completed, the examiner should introduce List B by saying, *"Now, I'm going to read another list of words. This time, again, you should say back as many words of this second list as you can remember. Again, the order in which you say the words does not matter. Just try to remember as many as you can."* Record the words remembered from the second list.

Immediate Delay: Immediately after completion of List B, say, *"Now tell me all the words that you can remember from the first list- not the second list, just the first list."* Make sure the participant understands you want just the words from the 1st list and not the 2nd list. Record each of the words recalled.

Recall Trial

After a time span of approximately 20 minutes (during which other testing will have taken place) from the time trial V and the interference trial were completed, the participant should be asked to recall as many of the 15 *original* words as possible. The examiner should say, "A while ago, I read a list of words to you several times, and you had to repeat back the words. Tell me all the words you can recall from that list." Record each of the words the participant can recall.

TRACK-TBI: RAVLT WORD LIST FORM 2

DATE ADMINISTERED:___________ SUBJECT ID__________ START TIME_________

Principal List	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	Interference List Recall Trial 1	Principal List Recall Trial 6	20 Minute Delay Principal List Recall Trial 7
Violin						Orange			
Tree						Table			
Scarf						Toad			
Ham						Corn			
Suitcase						Bus			
Cousin						Chin			
Earth						Beach			
Stairs						Soap			
Dog						Hotel			
Banana						Donkey			
Town						Spider			
Radio						Monkey			
Hunter						Book			
Bucket						Soldier			
Field						Padlock			
# of Correct Responses									

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3| 2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|
.
If 1.2 or 5.0(Other) Please Specify: ____________________

END TIME __________

DATE ADMINISTERED:___________ SUBJECT ID__________ START TIME__________

Trail Making Test (TMT)

Trail Making Test Part A	
Time (seconds)	

Trail Making Test Part B	
Time (seconds)	

Hand Used (check one): ☐ Dominant ☐ Non-Dominant

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

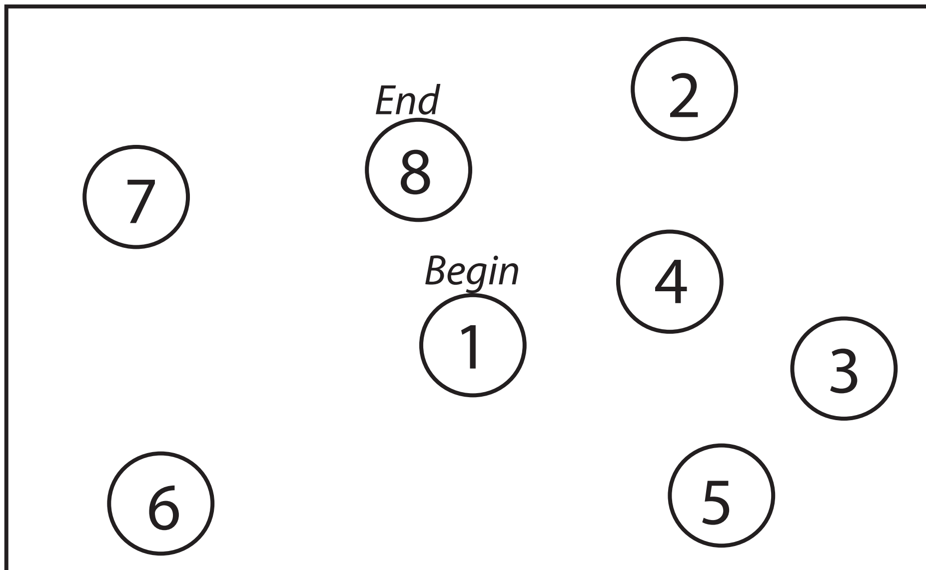
END TIME __________

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3| 2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|
.
If 1.2 or 5.0 (Other) Please Specify: ______________________

Trail Making Test

Part A

SAMPLE



17 21

15

20 19

16

18

4 22

5

13 6

Begin

1 24

7

14

2

8 10

3

9

End

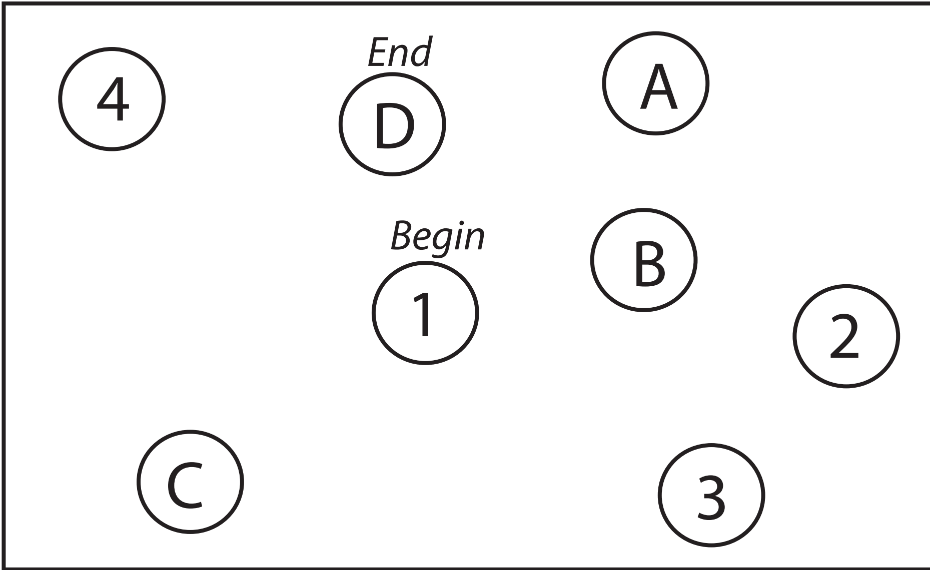
11 25

12 23

Trail Making Test

Part B

SAMPLE



End

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8 9 I D

B 4

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7

Begin

1

5

H

C

12

G

A J

2

L 6

F E

K 11

DATE ADMINISTERED:___________ SUBJECT ID__________ START TIME_________

WAIS IV

Symbol Search

Number of Correct Responses	
Number of Errors	

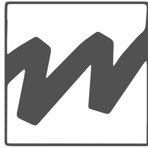
Coding

Number of Correct Responses	

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

END TIME __________

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3| 2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0| .
If 1.2 or 5.0(Other) Please Specify: ______________________



WAIS®-IV

Response Booklet 1

Symbol Search

Coding

Examinee Name:

Age:

Examiner Name:

Test Date:

Symbol Search

Demonstration Items

NO

NO

NO

Sample Items

NO

NO

NO

PROPRIETARY MEASURE CONTACT UCSF TO BE MAILED FORMS

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PEARSON PsychCorp

ISBN 015-4980-87-0

>	≮	>	⊅	⊖	<	∩	NO
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∩	⊕	⊖	∩	∪	⊞	∪	NO
∟	⫫	⧺	⋛	≂	⋋	∟	NO
⊏	⋗	⊙	⊞	≮	⋗	⊧	NO
⇉	‡	⊕	≮	⊄	⊞	⊂	NO
↷	≈	≈	⊢	↶	⋖	⌜	NO
∟	≮	⊧	⊕	±	⌟	⋖	NO
⊪	‡	∮	⧺	⋌	≬	∩	NO
⇁	⋌	⊗	⌟	±	⋌	⊂	NO

PROPRIETARY MEASURE
CONTACT UCSF TO BE
MAILED FORMS

C___ I___

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PROPRIETARY MEASURE
CONTACT UCSF TO BE
MAILED FORMS

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PROPRIETARY MEASURE
CONTACT UCSF TO BE
MAILED FORMS

Coding

1	2	3	4	5	6	7	8	9
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Demo Sample

6	8	3	9	5	4	1	7	2	1	4	8	2	7	6	9	3	5
8	3	1	9	2	5	6	4	3	7	2	9	8	1	4	7	6	5
9	1	2	4	7	2	5	6	9	5	8	6	4	3	1	7	8	3
1	3	9	6	3	9	7	5	1	4	2	8	7	2	8	5	6	4
7	6	4	1	3	2	8	1	7	9	2	5	3	4	8	6	5	9
8	1	9	5	1	4	2	6	9	8	7	3	5	6	4	7	2	3
3	6	8	9	1	8	4	7	5	2	9	6	7	1	5	2	3	4
6	4	1	9	5	7	3	6	8	3	2	7	5	8	4	2	9	1

PROPRIETARY MEASURE
CONTACT UCSF TO BE
MAILED FORMS

DATE ADMINISTERED:___________ SUBJECT ID__________ START TIME_________

Brief Symptom Inventory 18 (BSI 18)*

*Leonard R. Derogatis, PhD

Instructions:
The BSI 18 consists of a list of problems people sometimes have. Read each one carefully and circle the number of the response that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Circle only one number for each problem (0 1 ②3 4). Do not skip any items. If you change your mind, draw an X through your original answer and then circle your new answer (0 1 ⊗ 3 ④). Read the example before beginning. If you have any questions, please ask them now.

EXAMPLE

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

HOW MUCH WERE YOU DISTRESSED BY:

Body Aches...0 1 2 3 4

HOW MUCH WERE YOU DISTRESSED BY:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Faintness or dizziness	0	1	2	3	4
2. Feeling no interest in things	0	1	2	3	4
3. Nervousness or shakiness inside	0	1	2	3	4
4. Pains in heart or chest	0	1	2	3	4
5. Feeling lonely	0	1	2	3	4
6. Feeling tense or keyed up	0	1	2	3	4
7. Nausea or upset stomach	0	1	2	3	4
8. Feeling blue	0	1	2	3	4
9. Suddenly scared for no reason	0	1	2	3	4
10. Trouble getting your breath	0	1	2	3	4
11. Feelings of worthlessness	0	1	2	3	4
12. Spells of terror or panic	0	1	2	3	4
13. Numbness or tingling in parts of your body	0	1	2	3	4
14. Feeling hopeless about the future	0	1	2	3	4
15. Feeling so restless you couldn't sit still	0	1	2	3	4
16. Feeling weak in parts of your body	0	1	2	3	4
17. Thoughts of ending your life	0	1	2	3	4
18. Feeling fearful	0	1	2	3	4

PROPRIETARY MEASURE
CONTACT UCSF TO BE
MAILED FORMS

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0| .
If 1.2 or 5.0(Other) Please Specify: ____________________

END TIME __________

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc.): Page 44

Response Form

Glenn P. Smith, PhD

PROPRIETARY MEASURE
CONTACT UCSF TO BE
FORMS

Instructions

This booklet contains a series of statements. If you agree with a statement, or feel that it is true or usually true for you, circle **T** for **TRUE**. If you disagree with a statement, or feel that it is false or usually untrue for you, circle **F** for **FALSE**.

Please DO NOT SKIP ANY ITEMS. Please answer all of the items the best that you can, even if some are hard or do not seem to apply to you.

For example, if you **don't have** any problems with your memory, or if your memory changes have been gradual, you would circle **F** for this item:

I have had a sudden change in my memory. T (F)

If you make a mistake or want to change your answer, DO NOT ERASE. Draw an "X" through the answer you want to change, and then circle the correct answer:

I have had a sudden change in my memory. (T) (X)

Before you begin answering the items, please fill in your name, today's date, your gender, your age, and your date of birth in the spaces provided at the top of the next page.

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SIMS™ Response Form

Name ______________________ Today's Date ___/___/___

Gender ____________ Age ____________ Date of Birth ___/___/___

T = True or usually true for you **F = False or usually untrue for you**

#	Item	T	F
1.	Sometimes I lose all feeling in my hand so that it is as if I have a glove on.	T	F
2.	When my depression becomes too severe, I go out for long walks or do some form of exercise to reduce the tension.	T	F
3.	I believe that an individual's phone number is not randomly assigned but is God's way of determining one's salvation.	T	F
4.	If your shadow points to the southeast, the sun is in the northeast corner of the sky.	T	F
5.	Food doesn't taste the same as it has in the past.	T	F
6.	I seldom laugh.	T	F
7.	Gold and silver are alike because they're both metals.	T	F
8.	I have noticed that my shadow dances wildly even though I remain still.	T	F
9.	I can remember what I was doing one hour ago.	T	F
10.	I have noticed that my body changes shape even though my weight stays the same.	T	F
11.	The capital of Italy is Hungary.	T	F
12.	I have difficulty remembering my address.	T	F
13.	There is nothing that I can do, besides taking medication, that has any effect on the voices I hear.	T	F
14.	The United States has 55 states.	T	F
15.	The major problem I have is with my memory.	T	F
16.	Even though I'm depressed most of the time, I feel best in the morning after a good night's sleep.	T	F
17.	My mood is worse at night.	T	F
18.	More than three times a day I find myself getting up to get something only to forget what it was.	T	F
19.	At times I am so depressed I welcome going to bed early to "sleep it off."	T	F
20.	My major problem is that my brain is injured.	T	F
21.	There are six days in a week.	T	F
22.	Recently I've noticed that my memory is getting so bad that there have been entire days that I cannot recall.	T	F
23.	I seldom cry.	T	F
24.	The more depressed I get, the more I want to eat.	T	F
25.	At times I've been unable to remember the names or faces of close relatives so that they seem like complete strangers.	T	F
26.	Walking is difficult for me because of my problems with balance.	T	F
27.	I have difficulty remembering the day of the week.	T	F
28.	I believe that the government has installed cameras in stop lights to spy on me.	T	F
29.	Sometimes when writing a phone number, I notice that the numbers come out backwards even though I don't mean to do it.	T	F
30.	I have difficulty remembering today's date.	T	F
31.	People can put thoughts in my mind against my will.	T	F
32.	I have trouble sleeping.	T	F
33.	My past life and important events became a blur to me almost overnight.	T	F
34.	I believe that if you think very hard it is possible to actually see the thoughts of others.	T	F
35.	Sometimes my muscles go limp for no apparent reason so that my arms and legs feel as if they weigh a ton.	T	F
36.	I have difficulty remembering my phone number.	T	F

(continued)

PROPRIETARY MEASURE CONTACT UCSF TO BE FORMS

T = True or usually true for you **F = False or usually untrue for you**

No.	Statement	T	F
37.	As the day progresses my mood gets worse.	T	F
38.	The voice(s) that I hear, which others do not hear, has (have) never stopped since it (they) began.	T	F
39.	I have pain in my body which seems to feel like bugs crawling under the surface of my skin.	T	F
40.	I cannot remember whether or not I have been married.	T	F
41.	I cannot count backwards from 20 to 1 without making a mistake.	T	F
42.	Flowers have magical powers like the ability to talk to people.	T	F
43.	I have no trouble falling asleep but I wake up often during the night.	T	F
44.	There is a constant ringing in my ears.	T	F
45.	I was told of an angry meeting I had with someone, but I do not recall any of it.	T	F
46.	Candles are made of wax.	T	F
47.	I am depressed all the time.	T	F
48.	The voice(s) I hear, which no one else hears, come(s) from outside my head.	T	F
49.	While driving, I sometimes forget how to get home.	T	F
50.	I have difficulty recognizing written and spoken words.	T	F
51.	The fear I have of someone hurting me is so real that I know exactly how and when they would do it.	T	F
52.	I do not seem to have the energy I used to have.	T	F
53.	When I can't remember something, hints do not help.	T	F
54.	There has been no change in my sense of smell.	T	F
55.	When I'm "down," I can get a lift through my hobbies, interests, or friends.	T	F
56.	A judge and a lawyer are alike because they are both part of the legal system.	T	F
57.	One day, all of a sudden, I began to hear one or more voices that other people couldn't hear.	T	F
58.	A door and a gate are alike because they are both openings.	T	F
59.	Although I am able to move them with no difficulty, I have noticed several parts of my limbs are numb.	T	F
60.	I can't seem to express my feelings.	T	F
61.	I have difficulty remembering my birth date.	T	F
62.	In my visions, I often see parts of bodies covered with blood.	T	F
63.	Washington was our first President.	T	F
64.	At times my leg, below the knee, goes limp and I'm unable to move it.	T	F
65.	When I hear voices coming out of nowhere, I want to run but find I can't even walk without great difficulty.	T	F
66.	I work slowly and produce a small amount because my activities are so limited.	T	F
67.	If you have $1.50 and I take away fifty cents, you will have 75 cents left.	T	F
68.	In the series — 1 12 123 — the next response would be 456.	T	F
69.	When I hear voices, I feel as though my teeth are leaving my body.	T	F
70.	The major problem I am having is that things are hard for me to understand.	T	F
71.	Once a week I suddenly find myself cold even though the actual temperature is warm.	T	F
72.	Even though things seem pretty bad, I try to remain hopeful that they'll get better.	T	F
73.	A man had 56 apples and a neighbor gave him 37 more. He now has 83.	T	F
74.	I find lately that I suffer from headaches and dizziness just before I forget something.	T	F
75.	In the series — 11 22 33 — the next correct answer would be 44.	T	F

PROPRIETARY MEASURE
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FORMS

DATE ADMINISTERED:_________ SUBJECT ID:___________ START TIME:__________

Structured Inventory of Malingered Symptomatology (SIMS)

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0| .
If 1.3 or 5.0 (Other) Please Specify: ____________________

END TIME:____________

DATE ADMINISTERED:__________ SUBJECT ID:__________ START TIME:___________

TOMM: Score Sheet

by Tom Tombaugh, Ph.D.

Name:______________________________________ Date:____/____/____

Age:_____ Gender: Male ☐ Female ☐

Name of Administrator:____

Instructions:

Each trial lists both correct (**bold**, underlined) and incorrect (regular text) responses. While running the test, *circle the name of the item* that the respondent chooses. After administering the test, put a checkmark in the box beside each number that has a circled **bold** and underlined response. Add up the number of checkmarks in both columns to obtain the total number of correct responses and record it at the bottom of each trial.

PROPRIETARY MEASURE
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DATE ADMINISTERED:________ SUBJECT ID:________

TOMM Score Sheet: Trial 1

	A	B	
1.	**spinning wheel**	cookie	☐
2.	tent	**kleenex box**	☐
3.	dustpan	**mouse**	☐
4.	**quill pen**	teepee	☐
5.	birdbath	**can**	☐
6.	**suitcase**	comb	☐
7.	**pennant**	boat	☐
8.	gas pump	**musical notes**	☐
9.	ring	**guitar**	☐
10.	**hat**	Christmas tree	☐
11.	**muffin pan**	train	☐
12.	mailbox	**brush**	☐
13.	wheat	**axe**	☐
14.	**jack o' lantern**	coat hanger	☐
15.	wallet	**scissors**	☐
16.	safety pin	**elephant**	☐
17.	**saw**	door	☐
18.	**butterfly net**	lawn mower	☐
19.	pullout bed	**candle**	☐
20.	**motorcycle**	knife	☐
21.	fishing pole	**sewing machine**	☐
22.	**jack-in-the-box**	rocking chair	☐
23.	**bench**	fence	☐
24.	screw	**stool**	☐
25.	**toaster**	bow & arrow	☐
26.	T.V.	**light bulb**	☐
27.	**maple leaf**	boat	☐
28.	crutch	**wrench**	☐
29.	hoe	**cake**	☐
30.	**key**	sock	☐
31.	cloud	**rose**	☐
32.	**racket**	pencil	☐
33.	corn	**ladder**	☐
34.	**wheelbarrow**	fire hydrant	☐
35.	**whistle**	grapes	☐
36.	toilet paper	**birdhouse**	☐
37.	**shopping cart**	teddy bear	☐
38.	cigarettes	**ice cream**	☐
39.	**roller skates**	glue	☐
40.	cherries	**umbrella**	☐
41.	**life preserver**	mountains	☐
42.	wheelchair	**stapler**	☐
43.	**swing set**	bunk bed	☐
44.	soup ladle	**pail & shovel**	☐
45.	dice	**iron**	☐
46.	**carrot**	book	☐
47.	drum	**dart**	☐
48.	**paper clip**	bird cage	☐
49.	**vest**	telescope	☐
50.	end table	**mask**	☐

TOTAL Correct for Trial 1 = ☐

PROPRIETARY MEASURE
CONTACT UCSF TO BE
MAILED FORMS

Test of Memory Malingering

Total Correct: ____ / 50

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0| . If 1.3 or 5.0 (Other) Please Specify: ___________________

END TIME:____________

Boston Naming Test

The BNT is a proprietary measure. Contact UCSF to be supplied the forms.

spontaneous correct responses ______

Spontaneous responses include responses correct without a cue PLUS early items not administered per protocol [typically items 1-(30)]

# of correct responses with stimulus cue ____
# of correct responses with phonemic cue _____

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0| . If 1.3 or 5.0 (Other) Please Specify: ___________________

END TIME:____________

DATE ADMINISTERED:__________ SUBJECT ID:___________ START TIME:__________

Finger Tapping Assessment

Finger Tapping (Dominant)

Total Number Finger Taps (Trial 1): _________

Total Number Finger Taps (Trial 2): _________

Finger Tapping (Non-Dominant)

Total Number Finger Taps (Trial 1): _________

Total Number Finger Taps (Trial 2): _________

Dominant Hand: R L

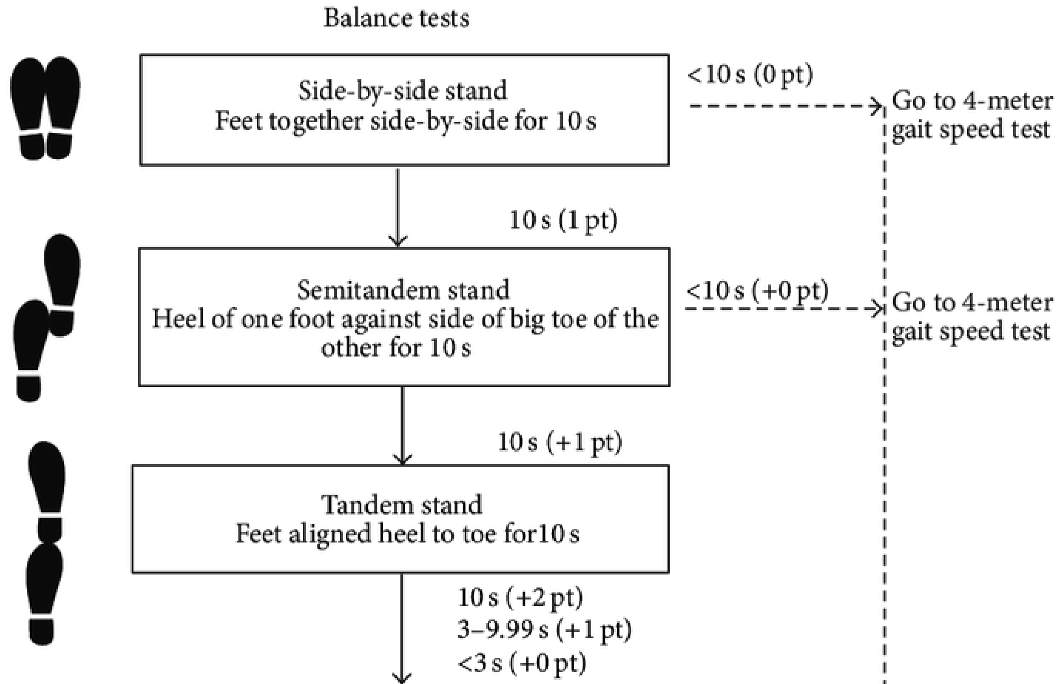
Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

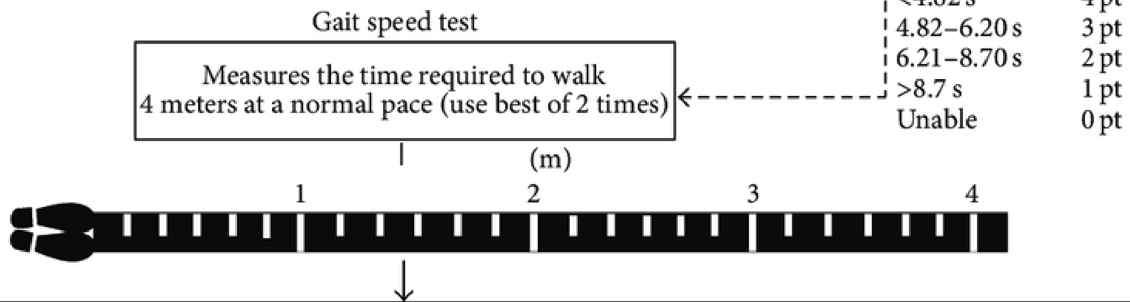
For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0| .
If 1.3 or 5.0 (Other) Please Specify: ____________________

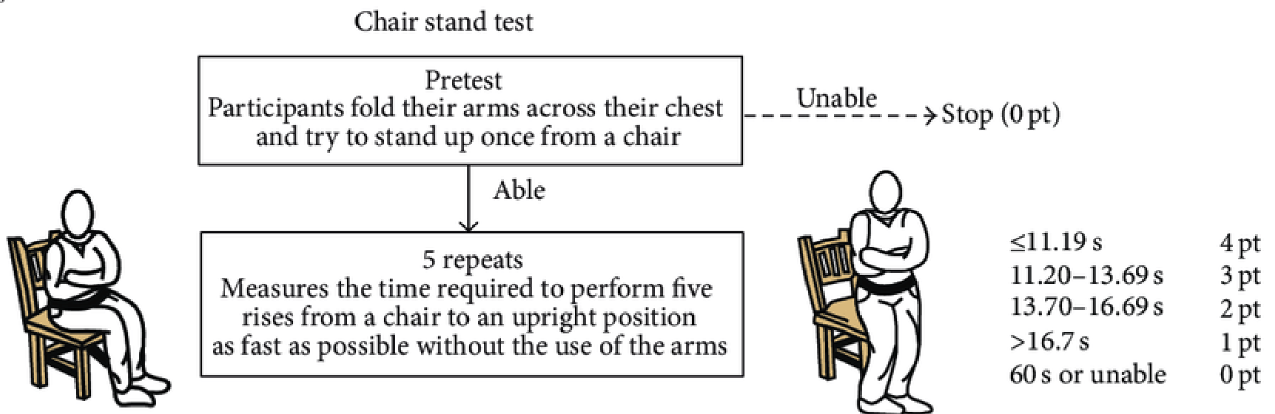
END TIME:____________

DATE ADMINISTERED:____________ SUBJECT ID__________ START TIME:_________

Short Physical Performance Battery (SPPB)







DATE ADMINISTERED:____________ SUBJECT ID___________

Balance Tests:

1. Side-by-side Stand

Held for 10s	❒ 1 pt
Held < 10s	❒ 0 pt, go to Gait Speed Test
Not attempted	❒ 0 pt, go to Gait Speed Test

Time held if less than 10 sec:_____._____sec

2. Semi-tandem Stand

Held for 10s	❒ 1 pt
Held < 10s	❒ 0 pt, go to Gait Speed Test
Not attempted	❒ 0 pt, go to Gait Speed Test

Time held if less than 10 sec:_____._____sec

3. Tandem Stand

Held for 10s	❒ 2 pts
Held for 3-9.99s	❒ 1 pt
Held for < 3s	❒ 0 pt
Not attempted	❒ 0 pt

Time held if less than 10 sec:_____._____sec

Balance Tests score:_______(sum of points for each trial)

If participant did not attempt test or failed, circle why	
Tried but unable	1
Unable to hold position unassisted	2
Not attempted, you felt unsafe	3
Not attempted, participant felt unsafe	4
Unable to understand instructions	5
Other (specify)_________________________	6
Participant refused	7

Gait Speed Test

4. First gait speed test time:_____._____sec
   Aids for walk…❒None ❒Cane ❒Other:______________

5. Second gait speed test time:_____._____sec
   Aids for walk…❒None ❒Cane ❒Other:______________

6. Record the faster of the two trials:_____._____sec

Unable to complete	❒ 0 pt
>8.70 sec	❒ 1 pt
6.21 – 8.70 sec	❒ 2 pts
4.82 – 6.20 sec	❒ 3 pts
<4.82 sec	❒ 4 pts

Gait Speed Tests score:_______(points assigned for faster trial)

If participant did not attempt test or failed, circle why	
Tried but unable	1
Unable to walk unassisted	2
Not attempted, you felt unsafe	3
Not attempted, participant felt unsafe	4
Unable to understand instructions	5
Other (specify)_________________________	6
Participant refused	7

Chair Stand Tests

7. Single Chair Stand Test

Participant stood without using arms	❒ Go to Repeated Chair Stand Test
Participant used arms to stand	❒ 0 pts, End test
Test not completed	❒ 0 pts, End test

8. Repeated Chair Test

Time to complete five stands: ___ ___ ._______sec

>60 sec/Unable to complete	❒ 0 pt
>16.70 sec	❒ 1 pt
13.70 - 16.69 sec	❒ 2 pts
11.20 – 13.69 sec	❒ 3 pts
<= 11.19 sec	❒ 4 pts

Repeated Chair Test score:______

If participant did not attempt test or failed, circle why	
Tried but unable	1
Unable to stand unassisted	2
Not attempted, you felt unsafe	3
Not attempted, participant felt unsafe	4
Unable to understand instructions	5
Other (specify)______________________	6
Participant refused	7

Total SPPB Points (add points from Balance Tests, Gait Speed Tests, and Repeated Chair Test scores):________

END TIME:_________

DATE ADMINISTERED:___________ SUBJECT ID__________

Short Physical Performance Battery (SPPB)- Test Completion Codes

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use Test Completion Code (circle one): 1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0| . If 1.3 or 5.0 (Other) Please Specify: ___________________

END TIME:____________

Stress/Trauma Question: Thank you for your answers to the previous questions. I am now going to ask you about stressful life events that occurred **in the past 12 months**.

Did you have any of the following stressful life events in the past 12 months? *(Check all that apply) (adapted from Army STARRS Life Stressors Questionnaire with permission)*

__ Serious illness or injury (unrelated to the study injury)
__ Separation, divorce, or other serious romantic break-up
__ Break-up or serious falling out with a close friend or relative
__ Betrayal by someone close to you
__ Job loss
__ Any other major financial crisis
__ A break-in or burglary of your home, car, or workplace
__ You were the victim of a mugging or armed robbery
__ You got into serious trouble with the police (e.g., arrested)
__ You got into serious legal trouble (e.g., an audit, a lawsuit)
__ Someone very close to you died
__ Someone very close to you had a life-threatening illness or injury
__ Someone very close to you had some other serious life crisis
__None of the above

If the participant endorsed any of the above answer options, say, Thank you for sharing this with me. I am so sorry that you are experiencing these difficult feelings. A lot of people experience feelings like this. There are resources that can help. I would be happy to provide you with contact information for an organization that can help locate assistance in your area. Would you like me to give you this information when we are finished? [*Share National Support and any Local Support options*].

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0| .
If 1.3 or 5.0 (Other) Please Specify: ____________________

END TIME:___________

DATE ADMINISTERED:____________ SUBJECT ID:____________ START TIME:____________

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version - Past Month

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and <u>underlined</u>.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) ***<u>Have you actually had any thoughts of killing yourself?</u>***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***<u>Have you been thinking about how you might do this?</u>*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***<u>Have you had these thoughts and had some intention of acting on them?</u>*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***<u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>*** (If yes to either part of 5, mark YES.)		

	YES	NO
6) ***<u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u>*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***<u>Was this within the past three months?</u>***		

- Low Risk
- Moderate Risk
- High Risk

If the subject selects YES for a question indicating moderate or high risk (orange or red), proceed with the TRACK-TBI Suicide Protocol and Safety Plan found on Dropbox in the "Outcomes Core SOP" folder.

Columbia Suicide Severity Rating Scale (C-SSRS)

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|
.
If 1.3 or 5.0 (Other) Please Specify: ____________________

END TIME __________

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

DATE ADMINISTERED:____________ SUBJECT ID:____________ START TIME:____________

Glasgow Outcome Scale—Extended (GOS-E)

CONSCIOUSNESS

1. Is the head injured person able to obey simple commands, or say any words?
1 ☐ No **(VS)** 2 ☐ Yes

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. Eye movements are not reliable evidence of meaningful responsiveness. Corroborate with nursing staff. Confirmation of VS requires full assessment as in the Royal College of Physician Guidelines.

INDEPENDENCE IN THE HOME

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

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

2b.Do they need frequent help or someone to be around at home most of the time?
1 ☐ No **(Upper SD)** 2 ☐ Yes **(Lower SD)**

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

2c. Was assistance at home essential before the injury? 1 ☐ No 2 ☐ Yes

INDEPENDENCE OUTSIDE THE HOME

3a. Are they able to shop without assistance? 1 ☐ No **(Upper SD)** 2 ☐ Yes

This includes being able to plan what to buy, take care of money themselves, and behave appropriately in public. They need not normally shop, but must be able to do so.

3b. Were they able to shop without assistance before the injury? 1 ☐ No 2 ☐ Yes

4a. Are they able to travel locally without assistance? 1 ☐ No **(Upper SD)** 2 ☐ Yes

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 without assistance before the injury? 1 ☐ No 2 ☐ Yes

WORK

5a. Are they currently able to work to their previous capacity? 1 ☐ No 2 ☐ Yes

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

5b. How restricted are they?
1 ☐ Reduced work capacity **(Upper MD)**
2 ☐ Able to work only in a sheltered workshop or non-competitive job or currently unable to work **(Lower MD)**

5c. Were they either working or seeking employment before the injury (answer 'yes') or were they doing neither (answer 'no')? 1 ☐ No 2 ☐ Yes

SOCIAL & LEISURE ACTIVITIES

6a. Are they able to resume regular social and leisure activities outside home? 1 ☐ No 2 ☐ Yes

They need not have resumed all their previous leisure activities, but should not be prevented by physical or mental impairment. If they have stopped the majority of activities because of loss of interest or motivation then this is also considered a disability.

6b. What is the extent of restriction on their social and leisure activities?
1 ☐ Participate a bit less: at least half as often as before injury **(Lower GR)**
2 ☐ Participate much less: less than half as often **(Upper MD)**
3 ☐ Unable to participate: rarely, if ever, take part **(Lower MD)**

6c. Did they engage in regular social and leisure activities outside home before the injury? 1 ☐ No 2 ☐ Yes

DATE ADMINISTERED:___________ SUBJECT ID:___________

FAMILY & FRIENDSHIPS

7a. Have there been psychological problems which have resulted in ongoing family disruption or disruption to friendships?

1 ☐ No 2 ☐ Yes

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?

1 ☐ Occasional - less than weekly **(Lower GR)**
2 ☐ Frequent - once a week or more, but tolerable **(Upper MD)**
3 ☐ Constant - daily and intolerable **(Lower MD)**

7c. Were there problems with family or friends before the injury? 1 ☐ No 2 ☐ Yes

If there were some problems before injury, but these have become markedly worse since injury then answer 'No' to Q7c.

RETURN TO NORMAL LIFE

8a. Are there any other current problems relating to the injury which affect daily life?

1 ☐ No **(Upper GR)** 2 ☐ Yes **(Lower GR)**

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

8b. Were similar problems present before the injury? 1 ☐ No 2 ☐ Yes

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

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.

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

GOS-E SCORE:

____

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use

Test Completion Code (circle one):

1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|

If 1.3 or 5.0 (Other) Please Specify: ____________________

END TIME:___________

DATE ADMINISTERED:____________ SUBJECT ID:____________ START TIME:____________

Dex Questionnaire Revised (DEX-R)

Independent-rating

This questionnaire looks at some of the difficulties that people sometimes experience. We would like you to read the following statements, and rate them on a five-point scale according to your experience of the person you know.

4. Finds it difficult to start something

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

5. Has difficulty planning for the future

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

6. Does or says embarrassing things when in the company of others

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

7. Has difficulties deciding what s/he wants to do

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

8. Tells people openly when s/he disagrees with them

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

9. Struggles to find the words s/he wants to say

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

Relationship to participant……………………………………..

10. Loses his/her temper easily

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

11. Finds it hard to stop repeating saying or doing things once started

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

12. Finds it difficult to notice if s/he makes a mistake or does something wrong

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

13. Has difficulty thinking ahead

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

14. Gets concerned when s/he has worrying thoughts

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

15. Seems unconcerned about how s/he should behave in certain situations

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

16. Has difficulty showing emotion

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

18. Gets over-excited about things and can get a bit 'over the top' at these times

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

DATE ADMINISTERED:____________ SUBJECT ID:____________

20. Tends to be very restless, and 'can't sit still' for any length of time

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

21. Gets events mixed up with each other, and gets confused about the correct order of events

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

23. Really wants to do something one minute, but couldn't care less about it the next

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

25. Finds it hard to complete tasks or activities without structure or direction

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

26. Finds it difficult to stop doing something even if s/he knows s/he shouldn't

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

28. Cries or laughs uncontrollably

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

29. Finds it difficult to keep his/her mind on something, and is easily distracted

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

31. Has problems trusting his/her memory

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

32. Will say one thing, but will do something different

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

35. Is unaware of, or unconcerned about, how others feel about his/her behaviour

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

36. Finds it difficult to do or concentrate on two things at once

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

37. Has trouble making decisions

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

Dex Questionnaire Revised (Dex-R) Independent-rating

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|
.
If 1.2 or 5.0 (Other) Please Specify: ____________________

END TIME __________

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

DATE ADMINISTERED:__________ SUBJECT ID:__________ START TIME:_________

TRACK-TBI LONG In-Person Informant Interview

Date of participant with TBI's study injury: see Pre-admin CRF and last study visit: see Pre-admin CRF

1.	Mode of Test Administration: _____ In-Person _____ Telephone
2.	Information was obtained from: _____ Spouse _____ Mother/Father _____ Sibling (specify):____) _____ Offspring (specify):____________________________________) _____ Other relative (specify):__________________________________) _____ Non-Relative (mate) _____ Non-Relative (friend) _____ Professional caregiver _____ Other (specify):_______________________________________)
2a.	When did you first meet the participant? (refer to Pre-Admin CRF and **check one**) _____ Before the study injury (administer all interview questions) _____ During (Name's) participation in the first TRACK-TBI Study (skip questions 4a and 4b) _____ After (Name's) participation in the first TRACK-TBI Study ended (skip questions 4a, 4b, and 5a-d)
3.	How well do you know ____________(study participant)? _____ Very well _____ Fairly well _____ Not well (Specify when and how the informant has been in contact with the study participant): ____
4.	Functional Assessment Scale: "*Now, I am going to ask some questions about his/her daily tasks. Please rate them over the last 4 weeks on the following items.*"
4a.	In the past four weeks, has he/she had any difficulty or did they need any help with writing checks, paying bills, or balancing a checkbook? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4b.	In the past four weeks, has he/she had any difficulty or did they need any help with assembling tax records, business affairs, or other papers?

	__ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4c.	In the past four weeks, has he/she had any difficulty or did they need any help with shopping alone for clothes, household necessities, or groceries? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4d.	In the past four weeks, has he/she had any difficulty or did they need any help with playing a game of skill such as bridge or chess, working on a hobby? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4e.	In the past four weeks, has he/she had any difficulty or did they need any help with heating water, making a cup of coffee, turning off the stove? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4f.	In the past four weeks, has he/she had any difficulty or did they need any help with preparing a balanced meal? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent

	__ Unknown
4g.	In the past four weeks, has he/she had any difficulty or did they need any help with keeping track of current events? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4h.	In the past four weeks, has he/she had any difficulty or did they need any help with paying attention to and understanding a TV program, book, or magazine? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4i.	In the past four weeks, has he/she had any difficulty or did they need any help with remembering appointments, family occasions, holidays or medications? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4j.	In the past four weeks, has he/she had any difficulty or did they need any help with traveling out of the neighborhood, driving, or arranging to take public transportation? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown

Examiners: Fill out the remaining questions if the subject is unable to answer on the Participant Interview. Otherwise, leave blank. If ending here, fill out test completion code information on following page.

TRACK-TBI LONG Informant Interview

Fill out only if not completing remaining questions with informant

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|
.
If 1.2 or 5.0 (Other) Please Specify: ____________________

END TIME:____________

5a1.	Since their study injury, have they been hospitalized or treated in an emergency room following an injury to their head or neck? ____ No ____ Yes, once ____ Yes, more than once ____ Unknown
5a2.	Since their study injury, have they injured their head or neck in a car accident or from crashing some other moving vehicle accident, e.g. car, truck, bicycle, van, all-terrain vehicle? ____ No ____ Yes, once ____ Yes, more than once ____ Unknown
5a3.	Since their study injury, have they injured their head or neck in a fall or from being hit by something? ____ No ____ Yes, once ____ Yes, more than once ____ Unknown
5a4.	Since their study injury, have they injured their head or neck in sports, e.g. football, soccer, skiing, blading, basketball, baseball, biking, horseback riding? ____ No ____ Yes, once ____ Yes, more than once ____ Unknown
5a5.	Since their study injury, have they injured their head or neck in a fight, assault, from being hit by someone or being shaken violently? ____ No ____ Yes, once ____ Yes, more than once ____ Unknown
5a6.	Since their study injury, have they been nearby when an explosion or blast occurred? ____ No ____ Yes, once ____ Yes, more than once ____ Unknown

If participant answered yes to any question from 5a1-5a6, then fill out head injury details below:

Cause	Date	Disposition	LOC	LOC Duration	Dazed/Memory Gap	Are there current difficulties in your daily life due to this injury?
□ Car/moving vehicle accident □ Fall/struck by □ Sport Injury □ Fight/Assault □ Blast □ Other		□ No Hospital □ ED □ Hospital Admit □ Hospital Admit with ICU	□ No □ Yes □ Unknown	□ <30 Min □ 30 min – 24 hrs □ >24 hrs	□ No □ Yes □ Unknown	□ No □ Yes □ Unknown
□ Car/moving vehicle accident □ Fall/struck by □ Sport Injury □ Fight/Assault □ Blast □ Other		□ No Hospital □ ED □ Hospital Admit □ Hospital Admit with ICU	□ No □ Yes □ Unknown	□ <30 Min □ 30 min – 24 hrs □ >24 hrs	□ No □ Yes □ Unknown	□ No □ Yes □ Unknown
□ Car/moving vehicle accident □ Fall/struck by □ Sport Injury □ Fight/Assault □ Blast □ Other		□ No Hospital □ ED □ Hospital Admit □ Hospital Admit with ICU	□ No □ Yes □ Unknown	□ <30 Min □ 30 min – 24 hrs □ >24 hrs	□ No □ Yes □ Unknown	□ No □ Yes □ Unknown
□ Car/moving vehicle accident □ Fall/struck by □ Sport Injury □ Fight/Assault □ Blast □ Other		□ No Hospital □ ED □ Hospital Admit □ Hospital Admit with ICU	□ No □ Yes □ Unknown	□ <30 Min □ 30 min – 24 hrs □ >24 hrs	□ No □ Yes □ Unknown	□ No □ Yes □ Unknown

To be used in conjunction with Patient Interview Examiner Interview Date: _________ UID: __________

New TBIs

Cause (car/moving vehicle accident; fall/struck by; Sports; Fight/Assault; Blast; Other)	Month/Year	Disposition (No Hospital; ED/Dr. Visit; Hospital Admit; ICU)	LOC (Yes; No; Unknown)	LOC Duration (< 30 min; 30 min to 24 hrs; >24 hrs)	Dazed/Memory Gap (Yes; No; Unknown)	Current difficulties? (If yes, details)

New Peripheral Injury:

Injury	Month/Year	Disposition (No Hospital; ED/Dr. Visit; Hospital Admit; ICU)	Current Problems? (If yes, details)

New Illnesses:

Illness (Heart Disease; Poisoning; Pneumonia; Infectious Disease; COVID; Mental Health; Other Nervous System; Illegal Drug Use; Cancer; Other)	Month/Year	Disposition (No Hospital; ED/Dr. Visit; Hospital Admit; ICU)	Current Problems? (If yes, details)

5b1.	Did they sustain any peripheral injuries (injuries to other parts of the body) since their study injury? ____ No (skip to 5c) ____ Yes one time ____ Yes, more than one time ____ Unknown (skip to 5c)
5b2.	Were they admitted to the ICU for any of the new peripheral injuries? ____ No (go to #5b3) ____ Yes, once (go to #5b5) ____ Yes, more than one time (go to #5b5) ____ Unknown (go to #5b3)
5b3.	Were they admitted to the hospital but not to the ICU for any of the new peripheral injuries? ____ No (go to #5b4) ____ Yes, once (go to #5b5) ____ Yes, more than one time (go to #5b5) ____ Unknown (go to #5b5)
5b4.	Were they treated and released from the ED, Dr. office or other outpatient service for any of their new peripheral injuries? ____ No ____ Yes, once ____ Yes, more than one time ____ Unknown
5b5.	Are there current difficulties in their daily life due to the new peripheral injury(ies)? ____ No ____ Yes; specify:____________________________ ____ Unknown; explain:_____________________
5c.	Have they experienced any other new medical issues or illnesses since their study injury that required hospitalization for any reason or caused major disruption in functioning and/or continues to cause ongoing problems? (e.g., heart disease, accidental poisoning, pneumonia, infectious disease, other nervous system disease, mental health difficulties [e.g., depression, anxiety, etc.], illegal drug use, etc.) ____ No ____ Yes; Specify: ____ ____ Unknown; explain: ____

5d.	Have they experienced any other new medical issues or illnesses since their study injury that required hospitalization for any reason or caused major disruption in functioning and/or continues to cause ongoing problems? (e.g., heart disease, accidental poisoning, pneumonia, infectious disease, other nervous system disease, mental health difficulties [e.g., depression, anxiety, etc.], illegal drug use, etc.) ____ No ____ Yes; Specify: ____ ____ Unknown; explain: _____________________________________
6.	Living situation/residence. Where are they 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 (irrespective of injury, not due to health, includes financial reasons related to the study injury) ___ 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
7.	If there has been a change in their 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 problem unrelated to study injury ___ Limitations resulting from a new injury reported in Q#3 of this interview ___ Financial problems related to the study injury ___ Financial problems unrelated to the study injury ___ Other:____________________________ ___ N/A – no change ___ Unknown

8a.	How many years of Education have they completed (as of today) _____________ ____ Unknown
8b.	What is their highest Level of Education Completed ___ Never attended/Kindergarten Only ___ 1st grade ___ 2nd grade ___ 3rd grade ___ 4th grade ___ 5th grade ___ 6th grade ___ 7th grade ___ 8th grade ___ 9th grade ___ 10th grade ___ 11th grade ___ 12th grade, no diploma ___ GED or equivalent ___ High school graduate ___ Some college, no degree ___ Associate degree occupational, technical, or vocational program ___ Associate degree academic program ___ Bachelor's degree (e.g., BA, AB, BS, BBA) ___ Master's degree (e.g., MA, MS, Meng, Med, MBA) ___ Professional school degree (e.g. MD, DDS, DVM, JD) ___ Doctoral degree (e.g., PhD, EdD) ___ Unknown
8c.	[Years of Education (automatically derived on QuesGen from Years & Level of Edu]

9a Gardner Parkinsonism Screening Questions								
				If Yes,				
				Symptom present before study injury? (skip section if Informant did not know participant prior to the study injury)		Course of symptom over the past year?		
Question	**Yes**	**No**	**Do not Know**	**Yes**	**No**	**Getting Better**	**Getting Worse**	**About the same**
1. Do they have trouble arising from a chair?								
2. Is their hand-writing smaller than it once was?								
3. Do people tell them that their voice is softer that it once was?								
4. Is their balance, when walking, poor?								
5. Do their feet suddenly seem to freeze in door-ways?								
6. Does their face seem less expressive than it used to?								
7. Do their arms and legs shake?								
8. Do they have trouble buttoning buttons?								
9. Do they shuffle their feet and take tiny steps when they walk?								
10. Do you feel they move more slowly or stiffly than other people their age?								
11. Do they walk with a stooped posture?								
12. Have you noticed that they don’t swing their arms when they walk as much as they used to?								

9b.	Have they been told by a healthcare professional that they have any of the following? *(Check all that apply)* __ Parkinson's Disease __ Mild Cognitive Impairment *(NOTE: this is a medical diagnosis that is often a precursor to dementia)* __ Alzheimer's Disease __ Other dementia __ Lou Gehrig's Disease/ALS __ No __ Unknown
	Please continue to next page

	Epilepsy Screening: The next several questions ask about epilepsy and seizures.
10.	(To the administrator) Which of the following sources of information were queried? (**check all that apply**) ___ Research Participant ___ Caregiver ___ Medical Record
	Has he/she had or has anyone ever told him/her that they had any of the following?
10a.	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
10b.	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
10c.	Any other type of repeated unusual attacks or convulsions lasting about 5 minutes or less? ___ No ___ Yes ___ Unknown
11.	Has anyone ever told you that you have seizure(s) or epilepsy? ___ No ___ Yes ___ Unknown
	If 1 or more of questions 14a, 14b, 14c or 15 = yes then ask questions 16 – 21. If 14a – 15 are each = no then skip question 16 – 21 and go to question 22.
12.	Did the most recent seizure(s) occur later than 7 days after the date of the traumatic brain injury? ___ No ___ Yes ___ Unknown
13.	Did they have seizures or epilepsy prior to the traumatic brain injury? ___ No ___ Yes ___ Unknown

14.	Were they diagnosed with epilepsy, a seizure disorder, or a single seizure after the date of the traumatic brain injury diagnosis? ___ No (skip to Q19) ___ Yes ___ Unknown
15	Date of diagnosis: _______________________________
16.	Who gave this diagnosis? ___ Neurosurgeon ___ Neurologist ___ Pediatric Neurologist ___ Primary Care Physician ___ Pediatrician ___ Psychiatrist ___ Psychologist ___ Nurse Practitioner ___ Physiatrist ___ Other, specify:_________________________
17.	Have they received medication for seizures or epilepsy? ___ No - never ___ Yes – Pre-injury only ___ Yes – Post injury but not currently ___ Yes – Currently ___ Unknown

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|
.
If 1.2 or 5.0 (Other) Please Specify: _____________________

END TIME:____________

E

TRACK-TBI LONG

Transforming Research and Clinical Knowledge in Traumatic Brain Injury Longitudinal

In-Person

Case Report Forms

Screening Protocol and Abbreviated Assessment Battery

In Order of Test Administration

DATE ADMINISTERED:__________ SUBJECT ID_________ START TIME________

Directions for Assessment of Speech Intelligibility

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 below:

____

____

____

Was speech intelligible? (choose one) ☐ 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? (choose one) ☐ Yes ☐ No

In the event that the participant cannot respond verbally or in writing to the sentence shown above, proceed to administration of the Modified GOAT or CRS-R as indicated in the Workflow Algorithm and proceed with the assessment.

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

END TIME __________

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3 | 2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|
.
If 1.2 or 5.0 (Other) Please Specify:________________________________

DATE ADMINISTERED:__________ SUBJECT ID_________ START TIME________

Galveston Orientation and Amnesia Test (GOAT)

Type of Administration: Standard_____

_____ 1. ***What is your name?*** (2)______________; ***When were you born?*** (4)______________

Where do you live? (4) ______________

_____ 2. ***Where are you now?*** (unnecessary to state name of hospital) city (5) ______________

building (5) ____________________

_____ 3. ***On what date were you admitted to the hospital?*** (5) ____________; ***How did you get to the hospital?***

(5) ____

_____ 4. ***What is the first event you can remember after the injury?*** (5) ______________________________;

Can you describe in detail (e.g., date, time, companions) the first event you recall after the injury? (5)

____

_____ 5 ***What is the last event you can recall before the injury?*** (5) _________________________________;

Can you describe in detail (e.g., date, time, companions) the last event you can recall before the injury?

(5) ____

_____ 6. ***What time is it now?*** _____:_____am pm (1 point for each ½ hour off after the first 1/2 hour off; max of 5 points)

_____ 7. ***What day of the week is it?*** __________ (1 point for each day off, max of 3 points)

_____ 8. ***What day of the month is it?*** __________ (1 point for each day off, max of 5 points)

_____ 9. ***What is the month?*** ___________ (5 points for each month off, max of 15 points)

_____ 10. ***What is the year?*** __________ (10 points for each year off, max of 30 points)

_____ Total error points

____ GOAT score (100 – error points)

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

END TIME __________

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3 | 2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|
.
If 1.2 or 5.0 (Other) Please Specify:________________________________

DATE ADMINISTERED:____________ SUBJECT ID:____________ START TIME:____________

Glasgow Outcome Scale—Extended (GOS-E)

CONSCIOUSNESS

1. Is the head injured person able to obey simple commands, or say any words?

1 ☐ No **(VS)** 2 ☐ Yes

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. Eye movements are not reliable evidence of meaningful responsiveness. Corroborate with nursing staff. Confirmation of VS requires full assessment as in the Royal College of Physician Guidelines.

INDEPENDENCE IN THE HOME

2a. Is the assistance of another person at home essential every day for some activities of daily living?

1 ☐ No 2 ☐ Yes

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

2b.Do they need frequent help or someone to be around at home most of the time?

1 ☐ No **(Upper SD)** 2 ☐ Yes **(Lower SD)**

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

2c. Was assistance at home essential before the injury? 1 ☐ No 2 ☐ Yes

INDEPENDENCE OUTSIDE THE HOME

3a. Are they able to shop without assistance? 1 ☐ No **(Upper SD)** 2 ☐ Yes

This includes being able to plan what to buy, take care of money themselves, and behave appropriately in public. They need not normally shop, but must be able to do so.

3b. Were they able to shop without assistance before the injury? 1 ☐ No 2 ☐ Yes

4a. Are they able to travel locally without assistance? 1 ☐ No **(Upper SD)** 2 ☐ Yes

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 without assistance before the injury? 1 ☐ No 2 ☐ Yes

WORK

5a. Are they currently able to work to their previous capacity? 1 ☐ No 2 ☐ Yes

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

5b. How restricted are they?

1 ☐ Reduced work capacity **(Upper MD)**

2 ☐ Able to work only in a sheltered workshop or non-competitive job or currently unable to work **(Lower MD)**

5c. Were they either working or seeking employment before the injury (answer 'yes') or were they doing neither (answer 'no')? 1 ☐ No 2 ☐ Yes

SOCIAL & LEISURE ACTIVITIES

6a. Are they able to resume regular social and leisure activities outside home? 1 ☐ No 2 ☐ Yes

They need not have resumed all their previous leisure activities, but should not be prevented by physical or mental impairment. If they have stopped the majority of activities because of loss of interest or motivation then this is also considered a disability.

6b. What is the extent of restriction on their social and leisure activities?

1 ☐ Participate a bit less: at least half as often as before injury **(Lower GR)**

2 ☐ Participate much less: less than half as often **(Upper MD)**

3 ☐ Unable to participate: rarely, if ever, take part **(Lower MD)**

6c. Did they engage in regular social and leisure activities outside home before the injury? 1 ☐ No 2 ☐ Yes

DATE ADMINISTERED:___________ SUBJECT ID:___________

FAMILY & FRIENDSHIPS

7a. Have there been psychological problems which have resulted in ongoing family disruption or disruption to friendships?

1 ☐ No 2 ☐ Yes

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?

1 ☐ Occasional - less than weekly **(Lower GR)**

2 ☐ Frequent - once a week or more, but tolerable **(Upper MD)**

3 ☐ Constant - daily and intolerable **(Lower MD)**

7c. Were there problems with family or friends before the injury? 1 ☐ No 2 ☐ Yes

If there were some problems before injury, but these have become markedly worse since injury then answer 'No' to Q7c.

RETURN TO NORMAL LIFE

8a. Are there any other current problems relating to the injury which affect daily life?

1 ☐ No **(Upper GR)** 2 ☐ Yes **(Lower GR)**

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

8b. Were similar problems present before the injury? 1 ☐ No 2 ☐ Yes

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

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.

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

GOS-E SCORE:

____

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use

Test Completion Code (circle one):

1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|

If 1.3 or 5.0 (Other) Please Specify: ____________________

END TIME:___________

DATE ADMINISTERED:___________ SUBJECT ID:___________ START TIME:___________

Dex Questionnaire Revised (DEX-R)

Independent-rating

This questionnaire looks at some of the difficulties that people sometimes experience. We would like you to read the following statements, and rate them on a five-point scale according to your experience of the person you know.

4. Finds it difficult to start something

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

5. Has difficulty planning for the future

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

6. Does or says embarrassing things when in the company of others

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

7. Has difficulties deciding what s/he wants to do

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

8. Tells people openly when s/he disagrees with them

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

9. Struggles to find the words s/he wants to say

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

Relationship to participant……………………………………..

10. Loses his/her temper easily

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

11. Finds it hard to stop repeating saying or doing things once started

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

12. Finds it difficult to notice if s/he makes a mistake or does something wrong

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

13. Has difficulty thinking ahead

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

14. Gets concerned when s/he has worrying thoughts

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

15. Seems unconcerned about how s/he should behave in certain situations

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

16. Has difficulty showing emotion

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

18. Gets over-excited about things and can get a bit ‘over the top’ at these times

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

DATE ADMINISTERED:____________ SUBJECT ID:____________

20. Tends to be very restless, and 'can't sit still' for any length of time

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

21. Gets events mixed up with each other, and gets confused about the correct order of events

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

23. Really wants to do something one minute, but couldn't care less about it the next

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

25. Finds it hard to complete tasks or activities without structure or direction

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

26. Finds it difficult to stop doing something even if s/he knows s/he shouldn't

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

28. Cries or laughs uncontrollably

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

29. Finds it difficult to keep his/her mind on something, and is easily distracted

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

31. Has problems trusting his/her memory

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

32. Will say one thing, but will do something different

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

35. Is unaware of, or unconcerned about, how others feel about his/her behaviour

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

36. Finds it difficult to do or concentrate on two things at once

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

37. Has trouble making decisions

☐ 0 Never ☐ 1 Occasionally ☐ 2 Sometimes ☐ 3 Fairly often ☐ 4 Very often

Dex Questionnaire Revised (Dex-R) Independent-rating

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|
.
If 1.2 or 5.0 (Other) Please Specify: ____________________

END TIME __________

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

TRACK-TBI LONG In-Person Informant Interview

Date of participant with TBI's study injury: see Pre-admin CRF and last study visit: see Pre-admin CRF

1.	Mode of Test Administration: _____ In-Person _____ Telephone
2.	Information was obtained from: _____ Spouse _____ Mother/Father _____ Sibling (specify):____) _____ Offspring (specify):___________________________________) _____ Other relative (specify):_________________________________) _____ Non-Relative (mate) _____ Non-Relative (friend) _____ Professional caregiver _____ Other (specify):_______________________________________)
2a.	When did you first meet the participant? (refer to Pre-Admin CRF and **check one**) _____ Before the study injury (administer all interview questions) _____ During (Name's) participation in the first TRACK-TBI Study (skip questions 4a and 4b) _____ After (Name's) participation in the first TRACK-TBI Study ended (skip questions 4a, 4b, and 5a-d)
3.	How well do you know ____________(study participant)? _____ Very well _____ Fairly well _____ Not well (Specify when and how the informant has been in contact with the study participant): ____
4.	Functional Assessment Scale: "*Now, I am going to ask some questions about his/hers daily tasks. Please rate them over the last 4 weeks on the following items.*"
4a.	In the past four weeks, has he/she had any difficulty or did they need any help with writing checks, paying bills, or balancing a checkbook? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4b.	In the past four weeks, has he/she had any difficulty or did they need any help with assembling tax records, business affairs, or other papers?

	__ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4c.	In the past four weeks, has he/she had any difficulty or did they need any help with shopping alone for clothes, household necessities, or groceries? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4d.	In the past four weeks, has he/she had any difficulty or did they need any help with playing a game of skill such as bridge or chess, working on a hobby? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4e.	In the past four weeks, has he/she had any difficulty or did they need any help with heating water, making a cup of coffee, turning off the stove? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4f.	In the past four weeks, has he/she had any difficulty or did they need any help with preparing a balanced meal? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent

	__ Unknown
4g.	In the past four weeks, has he/she had any difficulty or did they need any help with keeping track of current events? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4h.	In the past four weeks, has he/she had any difficulty or did they need any help with paying attention to and understanding a TV program, book, or magazine? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4i.	In the past four weeks, has he/she had any difficulty or did they need any help with remembering appointments, family occasions, holidays or medications? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown
4j.	In the past four weeks, has he/she had any difficulty or did they need any help with traveling out of the neighborhood, driving, or arranging to take public transportation? __ Not applicable (e.g., never did) __ Normal __ Has difficulty, but does by self __ Requires assistance __Dependent __ Unknown

Examiners: Fill out the remaining questions if the subject is unable to answer on the Participant Interview. Otherwise, leave blank. If ending here, fill out test completion code information on following page.

TRACK-TBI LONG Informant Interview

Fill out only if not completing remaining questions with informant

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|
.
If 1.2 or 5.0 (Other) Please Specify: ____________________

END TIME:____________

5a1.	Since their study injury, have they been hospitalized or treated in an emergency room following an injury to their head or neck? _____ No _____ Yes, once _____ Yes, more than once _____ Unknown
5a2.	Since their study injury, have they injured their head or neck in a car accident or from crashing some other moving vehicle accident, e.g. car, truck, bicycle, van, all-terrain vehicle? _____ No _____ Yes, once _____ Yes, more than once _____ Unknown
5a3.	Since their study injury, have they injured their head or neck in a fall or from being hit by something? _____ No _____ Yes, once _____ Yes, more than once _____ Unknown
5a4.	Since their study injury, have they injured their head or neck in sports, e.g. football, soccer, skiing, blading, basketball, baseball, biking, horseback riding? _____ No _____ Yes, once _____ Yes, more than once _____ Unknown
5a5.	Since their study injury, have they injured their head or neck in a fight, assault, from being hit by someone or being shaken violently? _____ No _____ Yes, once _____ Yes, more than once _____ Unknown
5a6.	Since their study injury, have they been nearby when an explosion or blast occurred? _____ No _____ Yes, once _____ Yes, more than once _____ Unknown

If participant answered yes to any question from 5a1-5a6, then fill out head injury details below:

Cause	Date	Disposition	LOC	LOC Duration	Dazed/Memory Gap	Are there current difficulties in your daily life due to this injury?
□ Car/moving vehicle accident □ Fall/struck by □ Sport Injury □ Fight/Assault □ Blast □ Other		□ No Hospital □ ED □ Hospital Admit □ Hospital Admit with ICU	□ No □ Yes □ Unknown	□ <30 Min □ 30 min – 24 hrs □ >24 hrs	□ No □ Yes □ Unknown	□ No □ Yes □ Unknown
□ Car/moving vehicle accident □ Fall/struck by □ Sport Injury □ Fight/Assault □ Blast □ Other		□ No Hospital □ ED □ Hospital Admit □ Hospital Admit with ICU	□ No □ Yes □ Unknown	□ <30 Min □ 30 min – 24 hrs □ >24 hrs	□ No □ Yes □ Unknown	□ No □ Yes □ Unknown
□ Car/moving vehicle accident □ Fall/struck by □ Sport Injury □ Fight/Assault □ Blast □ Other		□ No Hospital □ ED □ Hospital Admit □ Hospital Admit with ICU	□ No □ Yes □ Unknown	□ <30 Min □ 30 min – 24 hrs □ >24 hrs	□ No □ Yes □ Unknown	□ No □ Yes □ Unknown
□ Car/moving vehicle accident □ Fall/struck by □ Sport Injury □ Fight/Assault □ Blast □ Other		□ No Hospital □ ED □ Hospital Admit □ Hospital Admit with ICU	□ No □ Yes □ Unknown	□ <30 Min □ 30 min – 24 hrs □ >24 hrs	□ No □ Yes □ Unknown	□ No □ Yes □ Unknown

5b1.	Did they sustain any peripheral injuries (injuries to other parts of the body) since their study injury? ____ No (skip to 5c) ____ Yes one time ____ Yes, more than one time ____ Unknown (skip to 5c)
5b2.	Were they admitted to the ICU for any of the new peripheral injuries? ____ No (go to #5b3) ____ Yes, once (go to #5b5) ____ Yes, more than one time (go to #5b5) ____ Unknown (go to #5b3)
5b3.	Were they admitted to the hospital but not to the ICU for any of the new peripheral injuries? ____ No (go to #5b4) ____ Yes, once (go to #5b5) ____ Yes, more than one time (go to #5b5) ____ Unknown (go to #5b5)
5b4.	Were they treated and released from the ED, Dr. office or other outpatient service for any of their new peripheral injuries? ____ No ____ Yes, once ____ Yes, more than one time ____ Unknown
5b5.	Are there current difficulties in their daily life due to the new peripheral injury(ies)? ____ No ____ Yes; specify:____________________________ ____ Unknown; explain:_____________________
5c.	Have they experienced any other new medical issues or illnesses since their study injury that required hospitalization for any reason or caused major disruption in functioning and/or continues to cause ongoing problems? (e.g., heart disease, accidental poisoning, pneumonia, infectious disease, other nervous system disease, mental health difficulties [e.g., depression, anxiety, etc.], illegal drug use, etc.) ____ No ____ Yes; Specify: ____ ____ Unknown; explain: ____

5d.	Have they experienced any other new medical issues or illnesses since their study injury that required hospitalization for any reason or caused major disruption in functioning and/or continues to cause ongoing problems? (e.g., heart disease, accidental poisoning, pneumonia, infectious disease, other nervous system disease, mental health difficulties [e.g., depression, anxiety, etc.], illegal drug use, etc.) ____ No ____ Yes; Specify: ____ ____ Unknown; explain: _____________________________________
6.	Living situation/residence. Where are they 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 (irrespective of injury, not due to health, includes financial reasons related to the study injury) ___ 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
7.	If there has been a change in their 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 problem unrelated to study injury ___ Limitations resulting from a new injury reported in Q#3 of this interview ___ Financial problems related to the study injury ___ Financial problems unrelated to the study injury ___ Other:_____________________________ ___ N/A – no change ___ Unknown

8a.	How many years of Education have they completed (as of today) _____________ ____ Unknown
8b.	What is their highest Level of Education Completed ___ Never attended/Kindergarten Only ___ 1st grade ___ 2nd grade ___ 3rd grade ___ 4th grade ___ 5th grade ___ 6th grade ___ 7th grade ___ 8th grade ___ 9th grade ___ 10th grade ___ 11th grade ___ 12th grade, no diploma ___ GED or equivalent ___ High school graduate ___ Some college, no degree ___ Associate degree occupational, technical, or vocational program ___ Associate degree academic program ___ Bachelor’s degree (e.g., BA, AB, BS, BBA) ___ Master’s degree (e.g., MA, MS, Meng, Med, MBA) ___ Professional school degree (e.g. MD, DDS, DVM, JD) ___ Doctoral degree (e.g., PhD, EdD) ___ Unknown
8c.	[Years of Education (automatically derived on QuesGen from Years & Level of Edu]

9a Gardner Parkinsonism Screening Questions

				If Yes,				
				Symptom present before study injury? (skip section if Informant did not know participant prior to the study injury)		Course of symptom over the past year?		
Question	**Yes**	**No**	**Do not Know**	**Yes**	**No**	**Getting Better**	**Getting Worse**	**About the same**
1. Do they have trouble arising from a chair?								
2. Is their hand-writing smaller than it once was?								
3. Do people tell them that their voice is softer that it once was?								
4. Is their balance, when walking, poor?								
5. Do their feet suddenly seem to freeze in door-ways?								
6. Does their face seem less expressive than it used to?								
7. Do their arms and legs shake?								
8. Do they have trouble buttoning buttons?								
9. Do they shuffle their feet and take tiny steps when they walk?								
10. Do you feel they move more slowly or stiffly than other people their age?								
11. Do they walk with a stooped posture?								
12. Have you noticed that they don’t swing their arms when they walk as much as they used to?								

9b.	Have they been told by a healthcare professional that they have any of the following? *(Check all that apply)* __ Parkinson's Disease __ Mild Cognitive Impairment *(NOTE: this is a medical diagnosis that is often a precursor to dementia)* __ Alzheimer's Disease __ Other dementia __ Lou Gehrig's Disease/ALS __ No __ Unknown
	Please continue to next page

	Epilepsy Screening: The next several questions ask about epilepsy and seizures.
10.	(To the administrator) Which of the following sources of information were queried? (**check all that apply**) ___ Research Participant ___ Caregiver ___ Medical Record
	Has he/she had or has anyone ever told him/her that they had any of the following?
10a.	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
10b.	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
10c.	Any other type of repeated unusual attacks or convulsions lasting about 5 minutes or less? ___ No ___ Yes ___ Unknown
11.	Has anyone ever told you that you have seizure(s) or epilepsy? ___ No ___ Yes ___ Unknown
	If 1 or more of questions 10a, 10b, 10c or 11 = yes then ask questions 12 – 17. If 10a – 11 are each = no then skip question 12– 17.
12.	Did the most recent seizure(s) occur later than 7 days after the date of the traumatic brain injury? ___ No ___ Yes ___ Unknown
13.	Did they have seizures or epilepsy prior to the traumatic brain injury? ___ No ___ Yes ___ Unknown

14.	Were they diagnosed with epilepsy, a seizure disorder, or a single seizure after the date of the traumatic brain injury diagnosis? ___ No (skip to Q19) ___ Yes ___ Unknown
15.	Date of diagnosis: ________________________________
16.	Who gave this diagnosis? ___ Neurosurgeon ___ Neurologist ___ Pediatric Neurologist ___ Primary Care Physician ___ Pediatrician ___ Psychiatrist ___ Psychologist ___ Nurse Practitioner ___ Physiatrist ___ Other, specify:_________________________
17.	Have they received medication for seizures or epilepsy? ___ No - never ___ Yes – Pre-injury only ___ Yes – Post injury but not currently ___ Yes – Currently ___ Unknown

DATE ADMINISTERED____________ SUBJECT ID____________

18.	Do they currently use tobacco or vape? _____ No _____ Yes Respond to each N=No Y=Yes U=Unknown
	______ Filtered cigarettes; ______ Non-filtered cigarettes; ______ Low-tar cigarettes; ______ Cigars; ______ Pipes; ______ Chewing tobacco; ______ E cigarettes; ______ Other, specify: ________________________________
19.	How often do they 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
20.	How many drinks containing alcohol do they have on a typical day when they are drinking? _____ 1 or 2 _____ 3 or 4 _____ 5 or 6 _____ 7, 8, or 9 _____ Not applicable, have not had any alcohol since injury _____ Unknown
21.	How often do they have (if subject identifies as male, ask “five”; if subject identifies as female, ask “four”) or more drinks on one occasion? _____ Never _____ Less than monthly _____ Monthly

	_____ Daily or almost daily _____ Not applicable, have not had any alcohol since injury _____ Unknown
22.	In the last month, did they use any illicit or non-prescription drugs? 'We want 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 him/her, or chemicals they might have inhaled or 'huffed'. We also want to know if sometimes they took more than they should have of any drugs that have been prescribed to them." _____ No _____ Yes _____ Unknown
23.	Ask everyone, regardless of the answer above: Did they use Marijuana? ___ No (If the answer is 'YES" then ask, 'Was Marijuana prescribed to them) ___ Yes (Used Marijuana that was prescribed) ___ Yes (Used Marijuana that was NOT prescribed) (Note: if used both prescribed Marijuana and Marijuana that was not prescribed, code Marijuana as NOT prescribed) ___ Unknown
23a.	Ask everyone, regardless of the answer above: Did they use Cannabidiol (CBD) oil? ___ No (If the answer is 'YES" then ask, 'Was CBD oil prescribed to him/her) ___ Yes (Used CBD oil that was prescribed) ___ Yes (Used CBD oil that was NOT prescribed) (Note: if used both prescribed CBD oil and CBD oil that was not prescribed, code CBD oil as NOT prescribed) ___ Unknown
24.	**Skip this question if question #22 = No even if #23 = Yes**

DATE ADMINISTERED __________ SUBJECT ID ___________

	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) Codes: N=No Y= Yes U= Unknown ____a. Sedatives ____b. Tranquilizers or anti-anxiety drugs ____c. Painkillers ____d. Stimulants ____e. Marijuana, CBD oil, hash, THC, or grass ____f. Cocaine or crack ____g. Hallucinogens ____h. Inhalants or solvents ____i. Heroin ____j. Synthetic drugs like “fake marijuana” and “bath salts” (street names keep changing but “fake marijuana” and “bath salts” have persisted in the vernacular) ____k. Any OTHER substances or medicines they have used to get high (Specify:____)
25.	Since their last study visit have they 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
26.	The next question asks about using prescription pain relievers in any way a doctor did not direct them to use them. These would include drugs such as codeine, Vicodin, and others. Do not include over-the-counter pain relievers like Aspirin or Tylenol or Advil, only prescription pain relievers.

	When you answer this question, please think only about their use of the drug in any way a doctor did not direct him/her to use it, including using it without a prescription of their own, using it in greater amounts, more often, or longer than they were told to take it, using it in any other way a doctor did not direct them to use it. In the past 12 months, have they ever, even once, used any prescription pain reliever in any way a doctor did not direct them to use it? ___ No ___ Yes ___ Unknown
27.	Are they or were they involved in litigation due to their injury? ___ No ___ Yes, suing another party of insurance company ___ Yes, defendant in lawsuit ___ Both, suing and defendant ___ Unknown
28.	If they are not presently involved in litigation, are they planning on being involved? ___ No ___ Yes, planning on suing another party or insurance company ___ Yes, will probably be a defendant ___ Yes, both suing and defendant ___ Unsure ___ Other: ____ ___ Unknown
29.	If involved, have they received any settlement? ___ No ___ Yes ___ Not involved ___ Unknown

DATE ADMINISTERED __________ SUBJECT ID _________

30.	Is the study participant covered by any of the following types of health insurance? N=No Y=Yes U=Unknown ___ Self-pay (uninsured) ___ Insurance through a current or former employer (of this person or another family member) ___ Insurance purchased directly from an insurance company or on the health insurance exchange (this person or family member) ___ Medicare, for people 65 and older, or people with certain disabilities ___ Medicaid, Medical Assistance, 'the State' or any kind of government-assistance plan for those with low incomes or a disability ___ Medicaid Pending ___ TRICARE, VA or other military health care ___ Any other type of health insurance or health coverage plan ___ Refused
31.	During the last year, how much money did they receive from wages or salary, tips, commissions, or bonuses, or their own business or practice, before taxes and other deductions? ___ None ___ Less than $10,000 ___ $10,000 to $14,999 ___ $15,000 to $24,999 ___ $25,000 to $34,999 ___ $35,000 to $49,999 ___ $50,000 to $74,999 ___ $75,000 to $99,999 ___ $100,000 to $149,999 ___ $150,000 to $199,999 ___ $200,000 or more ___ Refused

_____ Unknown

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3|2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|
.

END TIME ____________

Confusion Assessment Protocol

START TIME __________

CTD Visual Picture Memory Test – Learning Trial (VPMT-1): ***I am going to show you pictures of common objects. Look carefully and try to remember each picture.*** Name each object as you point to it. Show each picture for 3 seconds. Circle form used.

Form A:	table	car	hammer	cup	key
Form B:	dog	knife	pants	boot	paint brush

TOTART Attentional Subtest (TAS): ***Now I want you to …***

A. ***… count forward from 1 to 20 as quickly as you can.***
_____correct _____incorrect

B. ***… count backwards from 20 to 1.*** (can cue 20, 19, 18, …)
_____correct _____incorrect

C. ***… recite (say) the months of the year.***
_____correct _____incorrect
Jan Feb Mar Apr May Ju Jul Aug Sept Oct Nov Dec

D. ***… recite (say) the months of the year backwards.***
_____correct _____incorrect
Dec Nov Oct Sept Aug Jul Ju May Apr Mar Feb Jan

CTD Vigilance (V1): ***I am going to read you a long series of letters. Whenever you hear the letter H, indicate by raising your hand at the wrist*** (demonstrate) ***or saying yes and then putting it back down. Let's try these letters to practice, B H D.*** Note whether patient follows instructions on this sample and repeat as necessary.

Read the letter list at the rate of one letter per 2 seconds. Put a slash mark through each letter the patient responds to and circle omissions (/ = response, O = omission). Circle form used. Alternate between forms on different administrations.

Form A: H E G H F E H D H F H C B F H A D H C E H I H G D H
C E B H E G H I H C H E H F C I H E B H G F D H B E

Form B: H B H A E H B H C F A H F H G H C G D H C B A H G D
E H C H B E H D G H D A F H B I F H E B H D H E H G

CTD Vigilance Score = Hits (correct targets identified) X 2 – Commissions (incorrect targets identified): ______ **(c_crcom1)**

DATE ADMINISTERED ___________ SUBJECT ID__________

CTD Comprehension (Comp): ***I am going to ask you some questions that can be answered yes or no. If your answer is yes, nod your head or say yes. If your answer is no, shake your head or say no.*** Read each question twice and circle correct answers. Alternate between forms on serial administrations.

Form 1

Will a stone float on water?	(no)
Can you use a hammer to pound nails?	(yes)
Do two pounds of flour weigh more than one?	(yes)
Will water go through a good pair of rubber boots?	(no)

Form 2

Will a leaf float on water?	(yes)
Is a hammer good for cutting wood?	(no)
Is one pound of flour heavier than two?	(no)
Will a good pair of rubber boots keep water out?	(yes)

Comp: _____/4

CTD Visual Picture Memory Test – Recognition (VPMT-2): ***Now I am going to show you some more pictures. Some you have just seen but others will be shown for the first time. Let me know whether or not you have seen the picture before by nodding your head or saying yes or shaking your head or saying no. Remember indicate yes if you have seen the picture before and no if you have not seen the picture before.*** (Circle correct answers.)

Form A	***Car***	(yes)	***Key***	(yes)
	Glass	(no)	***Truck***	(no)
	Lock	(no)	***Cup***	(yes)
	Table	(yes)	***Chair***	(no)
	Hammer	(yes)	***Saw***	(no)
Form B	***Fork***	(no)	***Toothbrush***	(no)
	Boot	(yes)	***Knife***	(yes)
	Paintbrush	(yes)	***Shoe***	(no)
	Cat	(no)	***Dog***	(yes)
	Dress	(no)	***Pants***	(yes)

Recognition: __________/10

END TIME __________

CAP-COG

DATE ADMINISTERED ___________ SUBJECT ID__________

1. Cognitive Impairment (CI):

					CI Score	CAP Score
	Correct	Incorrect				
TOTART Counting to 20 forward	2	0			______	
TOTART Counting to 20 backward	4	0			______	
TOTART Reciting months forward	2	0			______	
TOTART Reciting months backward	6	0			______	
	36	30-35	<30			
CTD Vigilance (hits X 2) - commissions	4	2	0		______	
	4	3	2, 1, 0			
CTD Comprehension	4	2	0		______	
	10	9	8 – 7	6 – 0		
CTD Recognition	6	4	2	0	______	
TOTAL SCORE					______	

Cognitive Impairment (Total possible score = 28. Scores ≤ 18 indicate substantial impairment and the Comprehensive Assessment Battery should not be administered) ______

Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):

For Administrative Use
Test Completion Code (circle one):
1.0| 1.1| 1.2| 1.3| 2.1| 2.2| 2.3| 2.4| 2.5| 2.6| 3.1| 3.2| 3.3| 3.4| 3.5| 3.6| 4.0| 5.0|
.
If 1.2 or 5.0 (Other) Please Specify: _____________________

END TIME ___________

DATE ADMINISTERED:__________ SUBJECT ID:__________ START TIME:__________

CRS-R

COMA RECOVERY SCALE-REVISED

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Administration and Scoring Guidelines

Joseph T. Giacino, Ph.D. and Kathleen Kalmar, Ph.D.

Center for Head Injuries
Edison, New Jersey

Johnson Rehabilitation Institution
Affiliated with JFK Medical Center

Updated 11-1-05

JFK COMA RECOVERY SCALE - REVISED ©2004

Record Form

This form should only be used in association with the "CRS-R ADMINISTRATION AND SCORING GUIDELINES" which provide instructions for standardized administration of the scale.

Patient:	**Diagnosis:**	**Etiology:**
Date of Onset:	**Date of Admission:**	

Date																
Week	**ADM**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
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																

Denotes emergence from MCS†

Denotes MCS *

BRAIN STEM REFLEX GRID ©2004

Record Form

Patient:	**Date:**						
Pupillary Light	Reactive						
	Equal						
	Constricted						
	Dilated						
	Pinpoint						
	Accommodation						
Corneal Reflex	Absent						
	Present Unilateral						
	Present Bilateral						
Spontaneous Eye Movements	None						
	Skew Deviation						
	Conjugate Gaze Deviation						
	Roving						
	Dysconjugate						
Oculocephalic Reflex	None						
	Abnormal						
	Full						
	Normal						
Postural Responses (Indicate Limb)	Abnormal Extension						
	Abnormal Flexion						

NOTES

AROUSAL FACILITATION PROTOCOL ©2004

GUIDELINES

1) The goal of this intervention is to prolong the length of time the patient maintains arousal (i.e. eye opening)

2) The protocol is administered anytime the patient is observed to:

- Exhibit sustained eyelid closure ***AND/OR***
- Stops following commands for a period of at least one minute.

3) Readminister the arousal facilitation protocol when:

- Sustained eye closure re-occurs ***OR***
- Behavioral responsiveness ceases despite sustained eye opening.

INTERVENTIONS

Deep Pressure:

1) Present deep pressure stimulation unilaterally to the face, neck, shoulder, arm, hand, chest, back, leg, foot, and toes. The muscle should be firmly grasped at its base between the thumb and forefinger. While squeezing the muscle firmly, it should be "rolled" back and forth through the finger tips three to four times. This procedure should be repeated sequentially working from the facial musculature to the toes. The examiner should assure that there are no internal lines, local injuries (e.g., fractures, contusions, decubiti) or systemic complications (e.g., heterotopic ossification) before administering deep pressure.

2) Administer same on contralateral side.

AUDITORY FUNCTION SCALE ©2004

Score	Item	Method	Response
4	***Consistent Movement to Command***	**1.** Observe frequency of spontaneous movement for a one minute interval (See **Baseline Observation** and **Command Following Protocol** on page 5). **2.** Choose at least 1 object-related and 1 non-object related command from the Command Following Protocol. The type of command chosen (eye, limb, oral) should be based on patient's physical capacity and should be of low spontaneous frequency. If time permits, more than one type of command from each category may be used. The command should be repeated once during the 10 second response interval. **a. Object-Related Eye Movement Commands:** Present 2 common objects simultaneously and approximately 16 inches apart within the patient's field of view. Ask the patient to look at the object named (i.e. "Look at the [name object]". Next, reverse the positions of the 2 objects and ask the patient to look at the ***same*** object again (i.e. "Look at the [name object]"). Administer two additional trials using the same 2 objects and repeat the above procedure with instruction to look at the ***other*** object on both trials. Two trials per object should be administered for a total of 4 trials. **b. Object-Related Limb Movement Command:** Present 2 common objects simultaneously and approximately 16 inches apart within the patient's field of view and within arm's (or leg's) length and ask the patient to touch the object named with their hand (or foot). Next, reverse the positions of the 2 objects and ask the patient to touch the ***same*** object again. Administer two additional trials using the same two objects and repeat the above procedure with instruction to touch the ***other object on both trials***. Two trials per object should be administered for a total of 4 trials. **c. Non-Object Related Commands:** Select at least 1 eye movement, limb movement or oral movement/vocalization command and present it over 4 trials at 15 second intervals. The same command should be used for all 4 trials. Movements that occur between commands (ie: after the response interval has elapsed) should be noted but not scored.	Clearly discernible and accurate responses occur within 10 seconds on all 4 trials administered. This item is credited only when ***all 4 trials*** of ***2 different*** commands are passed.
3	***Reproducible Movement to Command***	Same as above	3 clearly discernible responses occur over the 4 trials on any one of the object ***or*** non-object related commands.

Continued

AUDITORY FUNCTION SCALE ©2004

Score	Item	Method	Response
2	***Localization to Sound***	Standing behind the patient and out of view, present an auditory stimulus (eg. voice, noise) from the right side for 5 seconds. Perform a second trial presenting the auditory stimulus from the left side. Repeat above procedure for a total of 4 trials, 2 on each side.	Head and/or eyes orient toward the location of the stimulus on **both trials** in at least one direction. This item is scored when there is clear evidence of head and/or eye movement. It is not dependent on the degree or duration of movement.
1	***Auditory Startle***	Present a loud noise directly above the patient's head and out of view. Administer 4 trials.	Eyelid flutter or blink occurs immediately following the stimulus on at least 2 trials.
0	***None***	See above	No response to any of the above

BASELINE OBSERVATION AND COMMAND FOLLOWING PROTOCOL

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Commands	Baseline	Trial 1	Trial 2	Trial 3	Trial 4
	1 minute frequency count				
I Object Related Commands					
A. Eye Movement Commands					
Look at the *(object #1)*					
Look at the *(object #2)*					
B. Limb Movement Commands					
Take the *(name object #1)*					
Take the *(name object #2)*					
Kick the *(name object #1)*					
Kick the *(name object #2)*					
II Non-Object Related Commands					
A. Eye Movement Commands					
Look away from me					
Look up *(at ceiling)*					
Look down *(at floor)*					
B. Limb Movement Commands					
Touch my hand					
Touch your nose					
Move your *(object/body part)*					
C. Oral Movement/ Vocalization Commands					
Stick out your tongue					
Open your mouth					
Close your mouth					
Say "ah"					

	Yes:		No:	
Spontaneous Eye Opening	**Yes:**		**No:**	
Spontaneous Visual Tracking	**Yes:**		**No:**	

Resting Posture

RUE:	
RLE:	
LUE:	
LLE:	

VISUAL FUNCTION SCALE ©2004

Score	Item	Method	Response
5	***Object Recognition***	Same as Consistent Movement to Command on Auditory Function Scale, Section 2a and b (p. 3).	3 to 4 clearly discernible responses occur over the 4 trials administered.
4	***Object Localization: Reaching***	**1.** Identify the arm or leg with the greatest range of movement. **2.** For upper extremity reaching, select common ADL objects (e.g. comb, toothbrush, etc.). For lower extremity assessment, select a ball suitable for kicking. **3.** Present the object approximately 8 inches to the left or right of the limb's resting position. The object should be placed in a position that is not obstructed from view. The patient should be instructed to "Touch the ***(name object)*** " with the appropriate arm or leg. **4.** The command may be repeated once within the assessment interval. Do not provide any tactile cues, as these may stimulate random limb movement. **5.** Present an object twice to the left of the limb and twice to the right of the limb, in random order for a total of 4 trials.	Score the ***direction*** in which the limb ***first*** moves within a 10 second observation period, or score as no movement. The limb does not need to make contact with the object, only to move toward it; *and* Movement must occur in the correct direction on 3 of the 4 trials administered.
3	***Visual Pursuit***	Hold a hand mirror 4-6 inches directly in front of the patient's face and verbally encourage the patient to fixate on the mirror. Move mirror slowly 45 degrees to the right and left of the vertical midline and 45 degrees above and below the horizontal midline. Repeat the above procedure so that a total of 2 trials are administered in each plane.	Eyes must follow the mirror for 45 degrees ***without loss of fixation*** on 2 occasions in any direction. *If above criterion is not met, repeat the procedure assessing one eye at a time (using an eye patch).*
2	***Fixation***	Present a brightly colored or illuminated object 6 to 8 inches in front of the patient's face and then rapidly move to upper, lower, right and left visual fields for a total of 4 trials.	Eyes change from initial fixation poin and refixate on the new target location for more than 2 seconds. At least 2 episodes of fixation are required.
1	***Visual Startle***	Present visual threat by passing finger 1 inch in front of patient's eye. Be careful not to touch eyelashes or create a breeze (manually open eyes if necessary). Conduct 4 trials per eye.	Eyelid flutter or blink following presentation of visual threat on at least 2 trials with **either** eye.
0	***None***	See above	No response to any of the above.

MOTOR FUNCTION SCALE ©2004

<table>
<tr><th>Score</th><th>Item</th><th>Method</th><th>Response</th></tr>
<tr><td>6</td><td>Functional Object Use</td><td>Select 2 common objects (e.g. comb, cup). Place one of the objects in the patient's hand and instruct the patient to "Show me how to use a [name object]." Next, place the second object in the patient's hand and restate the same instruction.

Repeat the above procedure using the same objects so that a total of 2 trials are administered with each object.</td><td>Movements executed are generally compatible with both object's specific function (e.g. comb is placed on or near the head) on all 4 trials administered.

If the patient is unable to hold the object because of neuromuscular involvement, this should be noted on the record form and the item should not be scored.</td></tr>
<tr><td>5</td><td>Automatic Motor Response</td><td>Observe for automatic motor behaviors such as nose scratching, grasping bedrail that occur spontaneously during the examination.

If spontaneous automatic motor behaviors are not observed, present a familiar gesture (e.g. wave) in association with the following series of alternating commands:
1) "Show me how to wave" (demonstrate gesture).
2) "I'm going to wave again. Do not move at all. Just hold still." (demonstrate gesture).
3) "Show me how to wave" (demonstrate gesture).
4) "I'm going to wave again. Do not move at all. Just hold still." (demonstrate gesture).

For patients with limited ability to move the limbs, objects associated with oromotor activity may be used (e.g. spoon). Place the object in front of the patient's mouth without making contact. Administer the following series of alternating commands:
1) "Show me how to use (name object).
2) "I'm going to show you (name object) again. Do not move at all. Just hold still."
3) "Show me how to use (name object)."
4) "I'm going to show you (name object) again. Do not move at all. Just hold still."</td><td>At least 2 episodes of automatic motor behavior are observed within the session and each episode can be clearly differentiated from a reflexive response.

Patient performs the gesture (e.g. waves) on trials 2 and 4 (regardless of performance on trials 1 and 3).

Patient performs the oral movement pattern (e.g. mouth opening occurs when spoon is brought to mouth by examiner) on trials 2 and 4 (regardless of performance on trials 1 and 3).</td></tr>
</table>

Continued

MOTOR FUNCTION SCALE ©2004

Score	Item	Method	Response
4	***Object Manipulation***	Place a baseball size ball on the ***dorsal*** surface of one of the patient's hands. Roll the ball across the index finger and thumb without touching the undersurface of the hand or fingers. While moving the ball, instruct the patient to, "Take the ball." Repeat the above for a total of 4 trials.	The following criteria must be met on 3 of the 4 trials administered: **1.** The wrist must rotate and the fingers should extend as the object is moved along the dorsal surface of the hand; *and* **2.** The object must be grasped and held for a minimum of 5 seconds. The object cannot be held by means of a grasp reflex or increased finger flexor tone.
3	***Localization to Noxious Stimulation***	Extend all four extremities. Apply pressure to the finger or toe of an extremity (use best extremity on each side of the body) for a minimum of 5 seconds (ie.squeeze the finger or toe between your thumb and index finger). Administer 2 trials on each side for a total of 4 trials.	The non-stimulated limb must locate and make contact with the stimulated body part at the point of stimulation on at least 2 of the four trials.
2	***Flexion Withdrawal***	Extend all 4 extremities. Apply deep pressure to nailbeds of each extremity (ie. press the ridge of a pencil into the cuticle). Administer1 trial per extremity.	There is ***isolated*** flexion withdrawal of at least one limb. The limb must move ***away*** from the point of stimulation. If quality of response is uncertain, the trial may be repeated.
1	***Abnormal Posturing***	Observe response to above method	Slow, stereotyped flexion ***or*** extension of the upper and/or lower extremities occurs immediately after the stimulus is applied.
0	***None/Flaccid***	Observe response to above method	There is no discernible movement following application of noxious stimulation, secondary to hypertonic ***or*** flaccid muscle tone.

OROMOTOR/VERBAL FUNCTION SCALE ©2004

Score	Item	Method	Response
3	***Intelligible Verbalization***	**1.** Tell patient "I would like to hear your voice." This should be followed by an attempt to directly elicit speech using the verbal prompts shown below. At least one prompt should be selected from the Aural Set and at least one from the Visual Set. **2.** A maximum of 3 trials should be administered for each prompt chosen from the Aural and Visual Sets. Prompts should be administered at 15 second intervals. **Aural Set:** **a)** "What is your name?" **b)** "How are you today?" **c)** "Where do you live?" **Visual Set:** **a)** "What do you call this thing?" (Hold up common object in front of the patient's right and then left visual field for 10 seconds). **b)** "How many fingers am I holding up right now?" (Hold up 1 finger in front of the right and then left visual field for 10 seconds). **c)** "What part of my body is this?" (Point to your nose while positioned at the patient's visual midline).	Each of the following criteria must be met: **1.** Each verbalization must consist of at least 1 consonant-vowel-consonant (C-V-C) triad. For example, "ma" would not be acceptable, but "mom" would. Make sure objects chosen have a C-V-C sequence; *and* **2.** Two different words must be documented by the examiner to ensure that a repetitive word-like sound is not mistaken for a word. Words need not be appropriate or accurate for the context, but must be fully intelligible; *and* **3.** Words produced by writing or alphabet board are acceptable. *Verbalizations that occur spontaneously or at other times during the assessment and meet the above criteria should also receive a score of 3.*
2	***Vocalization / Oral Movement***	Observe for non-reflexive oral movements, spontaneous vocalizations or vocalizations that occur during administration of vocalization commands (see page 5).	At least one episode of non-reflexive oral movement and/or vocalization occurs spontaneously or in response to application of sensory stimulation. *Yawning is scored as reflexive oral movement.*
1	***Oral Reflexive Movement***	Present tongue blade between patient's lips and/or teeth	There is clamping of jaws, tongue pumping, or chewing movement following introduction of tongue blade into mouth.
0	***None***	See above	No response to any of the above.

COMMUNICATION SCALE ©2004

(if there is no evidence of reproducible command following or spontaneous communicative behavior, the Communication subscale is not administered)

Score	Item	Method	Response
2	***Functional: Accurate***	Administer the 6 Situational Orientation questions from the Communication Assessment Protocol (page12). The examiner may use the Visual set, Auditory set or both sets, if appropriate.	Clearly discernible and accurate responses occur on all 6 of the Visual ***or*** Auditory Situational Orientation questions from the Communication Assessment Protocol (see page 12).
1	***Non-Functional: Intentional***	Same as above	A clearly discernible communicative response* (e.g. head nods/shakes, thumbs up) must occur within 10 seconds on at least 2 of the 6 Situational Orientation questions (irrespective of accuracy). **The examiner must determine that this response occurs more frequently following verbal prompting (e.g. questions) than when non-specific auditory stimulation (e.g. hand clapping) is administered.*
0	***None***	See above	No discernible verbal or non-verbal communication responses occur at any time.

COMMUNICATION ASSESSMENT PROTOCOL ©2004

Situational Orientation

Visually Based				Aurally Based		
Am I touching my ear right now? (do not touch ear)				Am I clapping my hands right now? (do not clap)		
Am I touching my nose right now? (touch nose)				Am I clapping my hands right now? (clap)		
Am I touching my nose right now? (touch nose)				Am I clapping my hands right now? (clap)		
Am I touching my ear right now? (do not touch ear)				Am I clapping my hands right now? (do not clap)		
Am I touching my nose right now? (do not touch nose)				Am I clapping my hands right now? (clap)		
Am I touching my ear right now? (touch ear)				Am I clapping my hands right now? (do not clap)		
			Date			
Score						
of 6	of 6	of 6		of 6	of 6	of 6
			Date			
Score						
of 6	of 6	of 6		of 6	of 6	of 6

AROUSAL SCALE ©2004

Score	Item	Method	Response
3	***Attention***	Observe consistency of behavioral responses following verbal or gestural prompts.	There are no more than 3 occasions across the length of the evaluation in which the patient fails to respond to a verbal prompt.
2	***Eye Opening w/o Stimulation***	Observe status of the eyelids across length of assessment.	Eyes remain open across the length of the examination without the need for tactile, pressure or noxious stimulation.
1	***Eye Opening with Stimulation***	Same as above	Tactile, pressure or noxious stimulation must be applied at least once during the examination in order for the patient to sustain eye opening (the length of time the eyes remain open may vary and is not considered in the scoring).
0	***Unarousable***	See above	No eye opening noted.

ASSESSMENT OF CONTINGENT BEHAVIOR ©2004

(Supplementary Item)

Score	Item	Method	Response
Not Scored	***Contingent Vocalization / Gesture / Affective Response***	**1.** Vocalizations, gestures and affective responses are assessed through a combination of reports from family and clinicians, and direct observations from treating staff. Family and clinical staff should be questioned about any vocalizations, gestures or affective responses (i.e. smiling, laughing, frowning, crying) that are observed to occur spontaneously or in response to a specific stimulus. **2.** If above response is based on report, staff should attempt to directly elicit the behavior again with the assistance of the individual who reported it. **3.** If affective responses are observed during direct examination, the examiner should attempt to re-elicit the behavior using the same eliciting stimulus previously noted to produce the behavior. Examples of appropriate eliciting stimuli include verbal requests ("What's your name?"), limb gestures (wave), facial gestures (sticking out tongue) and pictures (family photos). **4.** The examiner should document: **a.** The nature of the eliciting stimulus (e.g. Verbal: "Are you feeling sad?"; Limb gesture: handshake); **b.** Specific characteristics of the behavioral response (e.g. facial grimace with tearing of the eyes; smiling, moaning); **c.** Number of times the behavior has been observed to occur within 10 seconds of the eliciting stimulus; **d.** Number of times the behavior has been observed to occur spontaneously; **e.** The time frame allowed for **"c"** and **"d"** should be specified and approximately the same.	A vocalization, gesture or affective response occurs significantly more often in response to a specific eliciting stimulus, than when the stimulus is absent. *Contingent responses do not include those that occur following administration of painful stimuli.*

RECORD DATE AND DESCRIPTION OF ABOVE STIMULI UTILIZED AND RESPONSES OBSERVED

DATE	ELICITING STIMULUS	TARGET BEHAVIOR	# SPONTANEOUS OCCURRENCES OF TARGET BEHAVIOR	# OCCURRENCES OF TARGET BEHAVIOR WITHIN 10 SEC OF ELICITING STIMULU

CRS-R TOTAL SCORE PROGRESS TRACKING CHART ©2004

Record Form

Patient:	Diagnosis:	Etiology:
Date of Onset:	Date of Admission:	

Date																
Week	**Adm**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
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