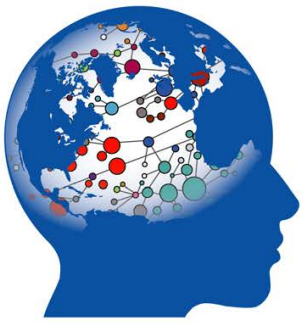


TRACK-TBI LONG

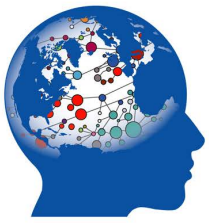
Transforming Research and Clinical Knowledge in Traumatic Brain Injury Longitudinal

TRACK-TBI LONG

Telephone

Case Report Forms

In Order of Test Administration



TRACK-TBI LONG

Transforming Research and Clinical Knowledge in Traumatic Brain Injury Longitudinal

TABLE of CONTENTS

*The GOSE and FSE are 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

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, 14, 15, 16
  - Informant Interview question 4a

Last study visit date (month, year):_____

- Forms involved and location of data point:
  - Participant Interview questions 3a, 3f, 3i, 8, 9b, 10a-d, 11b, 27
  - Informant Interview questions 4b, 5a-d

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:
  - FSE Home Management, Social Integration
  - Participant Interview question 6

Work/student status pre-injury:_____

- Forms involved and location of data point:
  - GOSE question 5
  - FSE Work and School
  - 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 ☐

Did you ask about potential Friend Controls? ☐

Has the participant's initial interview been completed? If not, administer during LONG call. ☐

DATE ADMINISTERED:_____ SUBJECT ID:_____ START TIME:_____

Has the subject died? Circle one. *No* *Yes*

Functional Status Examination

Traumatic Brain Injury Studies
University of Washington

Revised 4/18/13.

Contact Information:
Sureyya Dikmen, Ph.D.
Rehabilitation Medicine, Box 359612
325 Ninth Avenue
University of Washington | Seattle, WA 98104
Phone: (206) 685-7529, Fax: (206) 897-4881
E-mail: dikmen@u.washington.edu

DATE ADMINISTERED:_____ SUBJECT ID:_____

Personal Care

I am now going to ask you about your personal care activities. This refers to bathing, getting in/out of the tub or shower, shaving, brushing your teeth or hair, going to the bathroom, dressing or eating. After an injury, you may get help with one or more of these activities. For example, someone might help you bathe, dress, or help feed you or cut your food.

Due to your injury, is anyone helping you more now with your personal-care activities?

YES		***NO***		
Does someone help you with almost all of your important personal care needs, or just some?		Is there any *important* personal-care activity that you have stopped doing or that you are doing less often than before?		
ALMOST ALL	***JUST SOME***	***YES***	***NO***	
What are you getting help with? Explain.	What are you getting help with? Explain.	Explain.	Are you having more difficulty taking care of your personal care needs due to injury? Are you any slower, or less capable for any reason, including pain or feeling uncomfortable? Do you have more difficulty chewing or swallowing? Have problems with your memory, how you feel or any other changes made any of your personal care activities more difficult?	
			YES	***NO, SAME AS BEFORE***
			Explain.	
CODE 3	***CODE 2***		***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

Mobility/Ambulation

Now I am going to ask you some questions about your ability to get around in your home, yard or within a few blocks of your home with or without a cane, walker or wheelchair.

Due to your injury, are you unable to get from place to place within your immediate environment? Are other people helping you more now?? For example, does someone else push your wheelchair, hold onto you, guide you, go with you or help you get around at least part of the time (e.g., when you are outside, on uneven ground, or getting in or out of your bed or chair)?

YES		***NO***		
Are you almost always unable to get from place to place or is someone almost always with you or just some of the time?		Is getting around within your immediate environment restricted? Are you avoiding stairs, the outdoors, slopes, uneven ground, hills, etc.? (Include independent wheelchair users.)		
YES, ALMOST ALWAYS	***NO, JUST SOME***	***YES, RESTRICTED***	***NO***	
Explain.	What kind of help are you getting?	Explain.	Is getting from place to place more difficult for you now in any way due to your injury? Are you slower? Do you rest more often, tire more easily, or walk with an uneven gait or limp? Are you more unsteady? Have any other changes related to the injury made walking more difficult for you now?	
			YES	***NO, SAME AS BEFORE***
			Explain.	
CODE 3	***CODE 2***		***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

Mobility/Travel

The next questions have to do with your ability to get to places beyond a few blocks of your home (i.e., driving, riding a bus, train or taking a taxi or another way to get from place to place).

Due to your injury, is anyone helping you more now with transportation outside of your immediate environment? For example, is someone driving you places more often (e.g., during rush hour, long distances, when it is dark, in the city, etc.), or is someone going with you more often when you travel away from home?

YES		***NO***		
Is someone always with you when you travel or just some of the time)?		Is travel more limited now due to the injury? Are you driving less frequently or not going certain places? Are you avoiding driving at night, in bad weather, in the city, or in heavy traffic? Are you more limited to the bus train, taxi, etc.?		
YES, ALWAYS (Includes Non-Mobile Individuals)	***NO, JUST SOMETIMES***	***YES***	***NO***	
Explain.	When and how does someone help you?	Explain.	Is traveling from place to place more difficult for you now due to your injury? Are you less sure of yourself or more nervous? Are problems with vision, reaction time, coordination or strength, etc. making it more difficult? Have any other changes related to the injury made it more difficult to drive or get to where you need to be?	
			YES	***NO, SAME AS BEFORE***
			Explain.	
CODE 3	***CODE 2***		***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

If 1 or more of the following 3 questions = yes, administer this category
Pre-injury worker: 1=Yes 0=No
Worker now: 1=Yes 0=No
Would have been a worker now if not for the injury: 1=Yes 0=No 2=N/A
Work is primary: 1=Yes 0=No

Work

This section is about being self-employed, family-employed, or employed competitively by someone else.

Are you currently working?

NO, NOT WORKING DUE TO INJURY	***YES Working (or if not working and it's not due to the injury then ask the following questions hypothetically)***		
Explain.	Compared to your pre-injury work, are you currently earning less money (at least 25% less), or are you in a job which has less responsibility due to the injury? Have you received a demotion? Have you reduced your work hours by 25% or more? Is someone taking over any of your previous job duties?		
	YES	***NO***	
	Explain.	Are you having difficulty on the job now due to the injury? Is it taking you longer to get things done? Are problems with fatigue, concentration, memory, how you feel, or pain making your job harder? Are you having more trouble getting along with people at your job? Have you reduced your hours by <25%, or are you taking more days off from work due to your health? Do any other problems make work more difficult?	
		YES	***NO, SAME AS BEFORE***
		Explain.	
CODE 3	***CODE 2***	***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

If 1 or more of the following 3 questions = yes, administer this category
Pre-injury student: 1=Yes 0=No
Student now: 1=Yes 0=No
Would have been a student now, or had to drop out due to the injury: 1=Yes 0=No 2=N/A
School is primary: 1=Yes 0=No

School

This means classes taken for academic credit in a formal academic setting.

Are you currently attending school?

NO, NOT IN SCHOOL DUE TO INJURY	***YES in school (or if not in school and it's not due to the injury ask the following questions hypothetically)***		
Explain.	Compared to your pre-injury school, are you now taking fewer classes, easier classes or are you enrolled in an easier school due to your injury? Are you receiving extra help from others (e.g. note-taker, tutor, parents, etc.) to help you keep up your grades? Are you failing classes that you wouldn't have failed before?		
	YES	***NO***	
	Explain.	Are you having more difficulty with your classwork? Does it take you longer? Are you performing poorer? Are problems with memory, fatigue, or concentration making it more difficult for you now? Are you taking more time off? Do any other problems interfere with school?	
		YES	***NO, SAME AS BEFORE***
		Explain.	
CODE 3	***CODE 2***	***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

Home Management

The next questions are about your usual home care activities including cleaning, cooking, laundry, shopping, yard-care, car-care, home repair, home maintenance and childcare.

What were your normal home management responsibilities pre-injury?	**Living Situation**
	Pre-Injury:
	Post-Injury:

What are your home management responsibilities now?

Due to your injury, is anyone helping you more now with your usual home-care tasks or is someone else doing any of the home-care activities that you did before?

YES		***NO***		
Is someone else doing almost all of your usual home-care tasks or just some?		Are there any important home-care activities that you are avoiding now or performing less frequently than before due to the injury? Is there anything that you are not doing now?		
ALMOST ALL	***JUST SOME***	***YES***	***NO***	
Explain.	Explain.	Explain.	Is it harder for you to do any of your home-care activities now? Do you stop to rest more often? Are you slower, less capable for any reason, including pain or feeling uncomfortable? Do any other problems related to the injury interfere with your home management?	
			YES	***NO, SAME AS BEFORE***
			Explain.	
CODE 3	***CODE 2***		***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

Leisure and Recreation

The next questions are about what you like to do for fun during your free time like playing or watching sports, going to the movies, playing or listening to music, dancing, watching TV, reading, etc.

What did you do for fun pre-injury?

What do you do for fun now?

Due to your injury, have you dropped any of your usual fun activities, or are you receiving more help from anyone in order to continue to do them? Does anyone go with you more now while doing your fun activities, or drive you places so that you may do them?

YES		***NO***	
Have you dropped nearly all of your previous fun activities, or just some of them? Does someone always go with you or help you when doing those activities, or do they help you some of the time?		Are there any fun activities that you are performing less frequently or for shorter periods of time now due to your injury?	
ALMOST ALL	***DROPPED OR IS HELPED WITH <u>ONLY</u> <u>SOME</u> ACTIVITIES***	***YES***	***NO***
Explain.	Explain.	Explain.	Are your fun activities more difficult for you now due to your injury? Do you tire more easily, lose your balance, lose concentration, or perform them less capably for any reason? Do any other changes related to the injury make doing your leisure activities more difficult?
			YES / Explain.
			NO, SAME AS BEFORE
CODE 3	***CODE 2***		***CODE 1*** / ***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

Social Integration

Now I will ask you questions about your social relationships.

Who did you live with pre-injury?

Who do you live with now?

Due to your injury, are your social interactions more limited now? For example, do you have fewer friends now, less contact with friend and family, or are you spending less time with family or friends? Are you losing friends or having a harder time making new friends?

YES		***NO***		
Are your social interactions limited only to parents, *immediate* family, or to those where you live, due to the injury?		In order to maintain your prior social interaction, do you have to rely more on others? Are others going with you or driving you in order to socialize?		
YES, SOCIALLY ISOLATED	***NO, ONLY PARTIALLY LIMITED (i.e. fewer friends, less contact with friends, family, or less able to make new friends)***	***YES***	***NO***	
Explain.	Explain.	Explain.	Are you having more difficulty getting along with your friends and family due to the injury? Are your relationships more tense, awkward or less satisfying? Do any other changes related to the injury interfere with your socializing?	
			YES	***NO, SAME AS BEFORE***
			Explain.	
CODE 3	***CODE 2***		***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

Functional Status Exam (FSE)

What factors have contributed to the rating of the FSE (check all that apply):

- ☐ Study Injury
- ☐ New Injury: (specify)_____
- ☐ New or Worsened Neurological Condition:(specify)_____
- ☐ New or Worsened Mental Health Issues: (specify): _____
- ☐ Other: (specify): _____

☐ Not Applicable (No issues identified on the FSE)

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.

What factors have contributed to the rating of the GOSE (check all that apply):

- ☐ Study Injury
- ☐ New Injury: (specify)_____
- ☐ New or Worsened Neurological Condition:(specify)_____
- ☐ New or Worsened Mental Health Issues: (specify): _____
- ☐ Other: (specify): _____
- ☐ Not Applicable (Final rating = 8)

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:_____

Brief Test of Adult Cognition by Telephone (BTACT)

First I would like to make sure that you are able to hear me clearly. Please repeat these numbers after me: 2, 8, 3, 6, 9. ***(If not loud enough, ask person to speak up clearly.)*** Could you hear me clearly?

WORD LIST RECALL
Rey Auditory-Verbal Learning Test (Lezak, 1983) Form A

"I am going to read a list of 15 words. Listen carefully. When I am finished, you are to repeat as many of the words as you can remember. It doesn't matter in what order you repeat them. Just try to remember as many as you can. I will say each word only one time, and I cannot repeat any words. You will have up to one and a half minutes, and I will not say anything until I tell you that your time is up. Do you have any questions? Are you ready?"

(Read with one second interval between each word)

"Now tell me as many words as you can remember."

List A	Recall List A Trial 1	20 Minute Delay List A Recall
Drum		
Curtain		
Bell		
Coffee		
School		
Parent		
Moon		
Garden		
Hat		
Farmer		
Nose		
Turkey		
Color		
House		
River		
# of Correct Responses		

*(Record each word recalled in order **by writing down the first 1-2 letters of each word in the space above**). Plurals of a word are scored as Correct. Words not on the list or variants of words on the list (e.g., farm, home) are Intrusions.*

If person stops before 1 1/2 minutes is up, say, "There's still time left, can you think of any more?"
"Good, now let's go on.**"**

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: _____

DIGITS BACKWARD
WAIS III (1997)

"I am going to say some strings of numbers, and when I am done I would like you to repeat them backwards, in the reverse order from which I said them. So if I said "3, 8", you would say "8, 3". Do you understand? The sets will get larger as we go."

(Read in monotone, 1 sec per number. Drop your voice on the last digit to indicate it is time to respond. If they get the first trial on one level, move on to the next level. Discontinue after 2 trials missed on a level).

	Response	Correct?
2. 2 - 4 (4 - 2)	_____	_____
5 - 7 (7 - 5)	_____	_____
3. 6 - 2 - 9 (9 - 2 - 6)	_____	_____
4 - 1 - 5 (5 - 1 - 4)	_____	_____
4. 3 - 2 - 7 - 9 (9 - 7 - 2 - 3)	_____	_____
4 - 9 - 6 - 8 (8 - 6 - 9 - 4)	_____	_____
5. 1 - 5 - 2 - 8 - 6 (6 - 8 - 2 - 5 - 1)	_____	_____
6 - 1 - 8 - 4 - 3 (3 - 4 - 8 - 1 - 6)	_____	_____
6. 5 - 3 - 9 - 4 - 1 - 8 (8 - 1 - 4 - 9 - 3 - 5)	_____	_____
7 - 2 - 4 - 8 - 5 - 6 (6 - 5 - 8 - 4 - 2 - 7)	_____	_____
7. 8 - 1 - 2 - 9 - 3 - 6 - 5 (5 - 6 - 3 - 9 - 2 - 1 - 8)	_____	_____
4 - 7 - 3 - 9 - 1 - 2 - 8 (8 - 2 - 1 - 9 - 3 - 7 - 4)	_____	_____
8. 9 - 4 - 3 - 7 - 6 - 2 - 5 - 8 (8 - 5 - 2 - 6 - 7 - 3 - 4 - 9)	_____	_____
7 - 2 - 8 - 1 - 9 - 6 - 5 - 3 (3 - 5 - 6 - 9 - 1 - 8 - 2 - 7)	_____	_____

**Immediate self-corrections can be scored as correct.*

Enter the highest level reached (this is the longest number of digits correctly repeated in sequence) (Range 0, 2-8): _____

"Good, now let's go on.**"**

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: _____

CATEGORY FLUENCY
Drachman & Leavitt (1972)

"Now I am going to name a category and you will name things that belong in that category. Let's practice with the category "fruit". You could say peach, or pear. Can you think of any other fruits? (*wait for 2 correct items*). In a moment I will give you another category. When I say begin, you will name all the things from this **new** category you can think of, as fast as you can. You will have one minute to do this. I will let you know when your time is up. The new category is animals. Do you have any questions? Ready? Begin."
(Time for one minute).
If person stops before 1 minute is up, say "There's still more time, can you think of any more?"

(If person asks whether birds, fish, insects, reptiles, etc. are acceptable, say yes. If a participant says a category such as "bird", then names a specific, "robin", give credit for each. Do not accept mythical animals such as dragons and unicorns.)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

(Ask about any words you did not understand).

Scoring:
Total Number Correct: _____
Total Number of Repetitions: _____
Total Number of Intrusions: _____
"Good, now let's go on."

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: _____

RED/GREEN TEST

"Next I am going to see how quickly you can respond to the words RED and GREEN. Every time I say RED you will say STOP, and every time I say GREEN you will say GO. Try to be accurate, but respond as quickly as you can. So when I say RED you will say…(STOP)
And when I say GREEN you will say…(GO)
Do you have any questions? Let's begin. This will last about 1 minute."

(Do 20 trials. Allow 1 second between response and next cue. Record accuracy with 1 for correct answers, 0 for incorrect or self-corrections, X for invalid trials [trials are scored as invalid if the subject produces extraneous noises such as coughs, comments, or there are other external distractions that would invalidate the latency].)

RED/GREEN TASK: BASELINE NORMAL

ALLOW 1 SECOND BETWEEN TRIALS

Trial	Stimulus	Correct Response	Score
1	"GREEN"	GO	
2	"RED"	STOP	
3	"GREEN"	GO	
4	"RED"	STOP	
5	"RED"	STOP	
6	"GREEN"	GO	
7	"RED"	STOP	
8	"GREEN"	GO	
9	"RED"	STOP	
10	"GREEN"	GO	
11	"RED"	STOP	
12	"GREEN"	GO	
13	"GREEN"	GO	
14	"RED"	STOP	
15	"RED"	STOP	
16	"GREEN"	GO	
17	"RED"	STOP	
18	"GREEN"	GO	
19	"GREEN"	GO	
20	"RED"	STOP	
NORMAL CONDITION TOTAL CORRECT (0-20):			

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

**First clear response given is the one that's scored. Self-corrections are scored as INCORRECT.*

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: _____

"Now you will do just the reverse of what you have been doing. So when you hear RED you will say GO, and when you hear GREEN you will say STOP. Do you have any questions? When I say RED you will say…(GO) and when I say GREEN you will say…(STOP) Try to be accurate, but answer as quickly as you can."

(Do 20 trials. Allow one second between response and next cue. Record accuracy with 1 for correct answers, 0 for incorrect or self-corrections, X for invalid trials.)

RED/GREEN TASK: BASELINE SWITCHED

ALLOW 1 SECOND BETWEEN TRIALS

Trial	Stimulus	Correct Response	Score
1	"GREEN"	STOP	
2	"RED"	GO	
3	"GREEN"	STOP	
4	"RED"	GO	
5	"RED"	GO	
6	"GREEN"	STOP	
7	"RED"	GO	
8	"GREEN"	STOP	
9	"RED"	GO	
10	"GREEN"	STOP	
11	"RED"	GO	
12	"GREEN"	STOP	
13	"GREEN"	STOP	
14	"RED"	GO	
15	"RED"	GO	
16	"GREEN"	STOP	
17	"RED"	GO	
18	"GREEN"	STOP	
19	"GREEN"	STOP	
20	"RED"	GO	
SWITCHED CONDITION TOTAL CORRECT (0-20):			

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

**First clear response given is the one that's scored. Self-corrections are scored as INCORRECT.*

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: _____

"Now we are going to mix up these two types of responses. When I give the cue NORMAL, you will respond the way you did at first: red means stop, green means go. But when I say REVERSE , you will give the reverse responses: RED means GO, GREEN means STOP. We will alternate between the NORMAL and the REVERSE every few trials. Let's try a few for practice.

"NORMAL"	"RED"	(STOP)
	"GREEN"	(GO)
	"RED"	(STOP)
"REVERSE"	"GREEN"	(STOP)
	"RED"	(GO)
	"RED"	(GO)
"NORMAL"	"GREEN"	(GO)
	"RED"	(STOP)
	"GREEN"	(GO)
"REVERSE"	"GREEN"	(STOP)
	"RED"	(GO)

"Do you have any questions? Try to be accurate, but answer as quickly as you can. This will take about one minute."

(Stimulus and score sheet for Red/Green Test Experimental Condition are on next page)

(Allow 1 second between cue word (normal or switch) and stimulus color item. Allow 1 second between subject's response and the next stimulus item. Record accuracy with 1 for correct answers, 0 for incorrect or self-corrections, X for invalid trials.)
**First clear response given is the one that's scored. Self-corrections are scored as INCORRECT.*

RED/GREEN TASK: EXPERIMENTAL TRIALS

Trial	Condition	Stimulus	Correct Response	Score
1	"NORMAL"	"GREEN"	GO	
2		"RED"	STOP	
3		"GREEN"	GO	
4	"REVERSE"	"RED"	GO	
5		"RED"	GO	
6		"GREEN"	STOP	
7		"RED"	GO	
8		"RED"	GO	
9	"NORMAL"	"RED"	STOP	
10		"GREEN"	GO	
11		"RED"	STOP	
12		"GREEN"	GO	
13		"GREEN"	GO	
14		"RED"	STOP	
15	"REVERSE"	"GREEN"	STOP	
16		"GREEN"	STOP	
17		"RED"	GO	
18		"GREEN"	STOP	
19	"NORMAL"	"GREEN"	GO	
20		"RED"	STOP	
21		"GREEN"	GO	
22		"GREEN"	GO	
23		"RED"	STOP	
24	"REVERSE"	"GREEN"	STOP	
25		"GREEN"	STOP	
26		"RED"	GO	
27		"GREEN"	STOP	
28		"RED"	GO	
29	"NORMAL"	"RED"	STOP	
30		"GREEN"	GO	
31		"RED"	STOP	
32		"GREEN"	GO	
Enter Score for EACH ITEM on the NDB Data entry Form. **EXPERIMENTAL CONDITION TOTAL CORRECT (0-32): _____**				

"Good, now let's do something different."

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: _____

NUMBER SERIES (REASONING TEST)
Salthouse & Prill (1987)

"In the next exercise I will read you a series of numbers that may get larger or smaller in value. At the end you will try to figure out what the next number would be. So if the numbers were 2,4,6,8,10, the next number would be 12. After I say each number I will pause for as long as you need, and then you should say "okay" when you are ready for me to go on to the next number in the group. So if I said 2, you should say "okay" when you are ready for me to go on to the next number, then I say 4, you say "okay", 6, "okay", 8, "okay", 10, and at the end I will ask you what you think the next number would be. In this case the next number would be 12, as each number has increased by 2.

Let's try one for practice: 35 (okay), 30 (okay), 25 (okay), 20 (okay), 15 (okay) **AND** the next number would be….???? (The answer should be 10 as each number has decreased by 5). There will be different patterns, and some of these will be harder than others, so just do the best you can. If you are not sure of the answer, it is okay to guess. Do you have any questions?"

*(Pause after each of the first 4 items for okay response; after the last item, say **AND** the next number is…?). There is no discontinuation rule for this subtest.*

Trial	Stimulus	Correct Response	Response Given
1	18, 20, 24, 30, 38……	48	
	"Okay. Are you ready for another? The next set is:"		
2	81, 78, 75, 72, 69…….	66	
	"Okay. Are you ready for another? The next set is:"		
3	7, 12, 16, 19, 21……...	22	
	"Okay. Are you ready for another? The next set is:"		
4	28, 25, 21, 16, 10…….	3	
	"Okay. Are you ready for another? The next set is:"		
5	20, 37, 18, 38, 16…….	39	
Enter Score for EACH ITEM on the NDB Data entry Form. **TOTAL CORRECT (0-5):**			

**Immediate self-corrections can be scored as correct.*

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: _____

DATE ADMINISTERED:_____ SUBJECT ID:_____

BACKWARD COUNTING

"Next, I would like to see how fast you can count backwards. When I give the signal to begin, start counting backwards from 100 out loud, as fast as you can. So you will say 100, 99, 98 and so on. You will have half a minute. Do you have any questions? I will let you know when the time is up."

"Begin" *(Time for 30 seconds)*

On record form:

- / over **skipped** numbers (omissions)
- ← Over top of numbers to denote number **reversals**
- (#) For **incorrect** responses (errors)

RECORD FORM:

100	99	98	97	96	95	94	93	92	91	90
	89	88	87	86	85	84	83	82	81	80
	79	78	77	76	75	74	73	72	71	70
	69	68	67	66	65	64	63	62	61	60
	59	58	57	56	55	54	53	52	51	50
	49	48	47	46	45	44	43	42	41	40
	39	38	37	36	35	34	33	32	31	30
	29	28	27	26	25	24	23	22	21	20
	19	18	17	16	15	14	13	12	11	10
	9	8	7	6	5	4	3	2	1	

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

SCORING:

Last Number Reached: _____

Total Number of Errors (Reversals, skips, incorrect numbers)**:** _____

Total Number of Digits Produced (100- (number reached + number errors)): _____

"Good, now one more question."

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: _____

SHORT-DELAY WORD RECALL

"Do you remember the very first list of 15 words that I read to you in the beginning? It was the very first thing we did. (WAIT FOR SUBJECT TO RESPOND YES. MAKE SURE THEY UNDERSTAND THAT IT IS THE WORD LIST, NOT THE CATEGORY FLUENCY TEST). I want you to tell me as many of the words from that list as you can. You will have up to one minute. I will tell you when your time is up." ***(Record words recalled, on page 2 of the BTACT****. If person stops before 1 minute is up, say,* "there is still more time; can you think of any more?")

Thank you very much for your help. We appreciate your taking the time to help us with this research project.
THANK YOU!

END TIME _____

Your Health and Well-Being

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.
Thank you for completing this survey!

For each of the following questions, please mark an ☒ in the one box that best describes your answer.

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

Excellent	Very good	Good	Fair	Poor
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

2. The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a <u>Moderate activities</u>, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐ 1	☐ 2	☐ 3
b Climbing <u>several</u> flights of stairs	☐ 1	☐ 2	☐ 3

3. During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a <u>Accomplished less</u> than you would like	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Were limited in the <u>kind</u> of work or other activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

4. During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a <u>Accomplished less</u> than you would like	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Did work or other activities <u>less carefully than usual</u>	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

5. During the <u>past 4 weeks</u>, how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

6. These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the <u>past 4 weeks</u>…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a Have you felt calm and peaceful?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Did you have a lot of energy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c Have you felt downhearted and depressed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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:_____

QUALITY OF LIFE AFTER BRAIN INJURY – Overall Scale

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

These questions are about how you feel overall *now (including the past week).*	Not at all	Slightly	Moderately	Quite	Very
1. Overall, how satisfied are you with your physical condition?					
2. Overall, how satisfied are you with how your brain is working, in terms of your concentration, memory, thinking?					
3. Overall, how satisfied are you with your feelings and emotions?					
4. Overall, how satisfied are you with your ability to carry out day to day activities?					
5. Overall, how satisfied are you with your personal and social life?					
6. Overall, how satisfied are you with your current situation and future prospects?					

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:_____

PCL-5

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving *actual or threatened death, serious injury, or sexual violence*. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a *serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.*

First, please answer a few questions about your *worst event*, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse). Have you experienced any very serious events like this? Circle: yes/no. If yes: can you please briefly tell me what the event(s) was/were? Record here:_____ _____. If you have not experienced a very stressful event like the ones described, identify the most stressful event you have ever experienced, and then complete the questionnaire using that event as your reference for the remaining questions about how much that event has bothered you. Briefly identify the worst event if it is not described above (if you feel comfortable doing so): _____

How long ago did it happen? (please estimate if you are not sure) *mark one option below:*

<1 Month	1-6 Months	7-12 Months	1-2 Years	3-5 Years	6-10 Years	>10 Years

Note: If the event occurred between 6 and 7 months ago (i.e. 6 1/2 months ago), mark the 7-12 months box, etc.

Did it involve actual or threatened death, serious injury, or sexual violence?

_____Yes

_____No

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe _____

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____Accident or violence

_____Natural causes

_____Not applicable (the event did not involve the death of a close family member or close friend)

Second, keeping this worst event in mind, read each of the problems on the next page and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. (Note that if the 'worst event' occurred less than 1 month ago, use the time since the event for the time anchor)

DATE ADMINISTERED:_____ SUBJECT ID:_____

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

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: _____

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

END TIME _____

DATE ADMINISTERED:_____ SUBJECT ID:_____ START TIME:_____

Dex Questionnaire Revised (Dex-R)

Self-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.

4. I find it difficult to start something

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

5. I have difficulty planning for the future

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

6. I do or say embarrassing things when in the company of others

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

7. I have difficulties deciding what I want to do

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

8. I tell people openly when I disagree with them

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

9. I struggle to find the words I want to say

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

10. I lose my temper easily

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

11. I find it hard to stop repeating saying or doing things once I've started

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

12. I find it difficult to notice if I make a mistake or do something wrong

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

13. I have difficulty thinking ahead

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

14. I get concerned when I have worrying thoughts

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

15. I am unconcerned about how I should behave in certain situations

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

16. I have difficulty showing emotion

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

18. I get 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. I tend 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. I get events mixed up with each other, and get confused about the correct order of events

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

23. I really want 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. I find it hard to complete tasks or activities without structure or direction

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

26. I find it difficult to stop myself from doing something even if I know I shouldn't

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

28. I find myself crying or laughing uncontrollably

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

29. I find it difficult to keep my mind on something, and am easily distracted

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

31. I have problems trusting my memory

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

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

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

35. I am unaware of, or unconcerned about, how others feel about my behaviour

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

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

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

37. I have trouble making decisions

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

DATE ADMINISTERED:_____ SUBJECT ID:_____

Dex Questionnaire Revised (Dex-R) Self-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 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:_____)
3a.	Have you sustained another traumatic brain injury since your study injury? ____ No – skip to #3f ____ Yes once ____ Yes more than once ____ Unknown – skip to #3f
3b.	Did you sustain any new traumatic brain injury due to falling? ____ No ____ Yes once ____ Yes more than once ____ Unknown
3c.	Did any of the new traumatic brain injuries involve loss of consciousness? ____ No ____ Yes once ____ Yes more than once ____ Unknown
3d1.	Were you admitted to the ICU for any of the new traumatic brain injury(ies)? ___ No (go to #3d2) ___ Yes, once (go to #3e) ___ Yes, more than one time (go to #3e) ___ Unknown (go to #3d2)

3d2.	Were you admitted to hospital but not to ICU for any of the new traumatic brain injury(ies)? ____ No (go to #3d3) ____ Yes, once (go to #3e) ____ Yes, more than one time (go to #3e) ____ Unknown (go to #3d3)
3d3.	Were you treated and released from the ED, Dr. office or other outpatient service for any of your new traumatic brain injury(ies)? ____ No ____ Yes, once ____ Yes, more than one time ____ Unknown
3e.	Are there current difficulties in your daily life due to the new traumatic brain injury(ies)? ____ No ____ Yes; Specify_____ ____ Unknown; Explain _____
3f.	Did you sustain any peripheral injuries (injuries to other parts of the body) since your study injury? ____ No (skip to 3i) ____ Yes one time ____ Yes, more than one time ____ Unknown (skip to 3i)
3g1.	Were you admitted to the ICU for any of the new peripheral injuries? ____ No (go to #3g2) ____ Yes, once (go to #3h) ____ Yes, more than one time (go to #3h) ____ Unknown (go to #3g2)
3g2.	Were you admitted to the hospital but not to the ICU for any of the new peripheral injuries? ____ No (go to #3g3) ____ Yes, once (go to #3h) ____ Yes, more than one time (go to #3h) ____ Unknown (go to #3h)
3g3.	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

3h.	Are there current difficulties in your daily life due to the new peripheral injury(ies)? ____ No ____ Yes ____ Unknown
3i.	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
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

8. [**Skip question for Trauma Controls and Friend Controls]**

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

If yes, what type of healthcare provider (check all that apply), and what type of appointment was it?

Type of healthcare provider Indicate below for each healthcare provider: 1 = No, 2 = Yes 1 time, 3 =Yes, 2-5 times, 4 = Yes, 6 or more times, 9 = Unknown	Type of appointment? (1 = Consult only, 2 = Treatment, 8 = N/A did not visit this healthcare provider; 9 = Unknown)
General practitioner (primary care) ___	
Brain injury/Concussion Clinic ___	
Neurologist ___	
Physiatrist (Rehab doctor) ___	
Chiropractor ___	
Psychiatrist ___	
Psychologist, Neuropsychologist, psychological services ___	
Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.) ___	
Neurosurgeon ___	
Pain Specialist ___	
Rehabilitation therapist (e.g., physical, occupational, or speech therapist) ___	
Other (specify):_____	

	[Examiner: help the participant answer the following question by asking them to recall when they first received treatment and then when treatment ended (i.e., answer only if Type of Appointment = 2 "Treatment")] How long did you receive outpatient treatment? ___ < 2 weeks ___ 2-4 weeks ___ 5-8 weeks ___ 9-12 weeks ___ > 12 weeks ___ Active outpatient rehab ongoing ___ Annual check up ___ Unknown ___ N/A
	Gardner Motor/Parkinsonism/Neurodegenerative Disease Screen
9a.	Compared with before your study injury, do you currently have difficulty with any aspect of movement or walking such as: tremors or shaking of your arms or legs, smaller handwriting, difficulty buttoning clothes, softer or quieter voice, reduced facial expression, shuffling your feet or taking tiny steps when you walk, poor balance leading to falls or near-falls, difficulty with coordination of your hands or arms or legs, or overall slowness of movement? ___ Yes; new symptom(s) now not present pre-injury ___ Yes; symptom(s) present pre-injury but worse now ___ No; symptom(s) never present or present pre-injury but not worse now (Skip Q9b, go to 9c) ___ Unknown
9b.	Is this difficulty with movement or walking doing overall BETTER, ABOUT THE SAME, or WORSE since your last study visit? *[Note: If multiple movement/walking symptoms are endorsed then any worsening symptom takes precedence]* ___ Much Better ___ Better ___ About the same ___ Worse ___ Much Worse ___ Unknown

9c.	Have you ever been told by a health care provider that you have Parkinson's disease, Mild Cognitive Impairment (MCI*), Alzheimer's disease (AD), any other type of dementia, or Lou Gehrig's disease/ALS? *MCI is defined by PROGRESSIVELY WORSENING deficits in memory or thinking that do not yet significantly impact daily functioning ___ Yes ___ No ___ Unknown If yes, circle which may apply: Parkinson's disease, Mild Cognitive Impairment (MCI), Alzheimer's disease (AD), any other type of dementia, Lou Gehrig's disease/ALS
9d.	Do you think you may have Parkinson's disease, Mild Cognitive Impairment (MCI), Alzheimer's disease (AD), any other type of dementia, or Lou Gehrig's disease/ALS? ___ Yes ___ No ___ Unknown If yes, circle which may apply: Parkinson's disease, Mild Cognitive Impairment (MCI), Alzheimer's disease (AD), any other type of dementia, Lou Gehrig's disease/ALS
	"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."
10a.	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
10b.	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

10c.	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
10d.	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
	Caregiver Time
11a.	We need to understand difficulties people may have with various activities because of a health or physical problem. Please tell me whether you require help doing everyday activities such as the following: getting across a room, dressing, bathing, eating, getting in/out of bed, using the toilet, preparing meals, shopping for groceries, making telephone calls, taking your medications, managing your money. ___ Never (skip to question #12) ___ Rarely ___ Sometimes ___ Most of the time ___ Always ___ Don't know (skip to question #12) ___ Refused
11b.	Do you think the amount of help you need has increased since your last study visit? ___ No ___ Yes ___ Unknown

11c.	Who ***most often*** helps you with these tasks? ___ Spouse/partner ___ Child ___ Other family member ___ Friend ___ Volunteer or other unpaid ___ Home health care worker ___ Employee of the place where you live ___ Other paid ___ Don't know ___ Refused
	Epilepsy Screening
12.	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?
12a.	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
12b.	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
12c.	Any other type of repeated unusual attacks or convulsions lasting about 5 minutes or less? ___ No ___ Yes ___ Unknown
13.	Has anyone ever told you that you have seizure(s) or epilepsy? ___ No ___ Yes ___ Unknown
	If 1 or more of questions 12a, 12b, 12c or 13 = yes then ask questions 14 – 19. If 12a – 13 are each = no then skip question 14 – 19 and go to question 20.

14.	Did the most recent seizure(s) occur later than 7 days after the date of the traumatic brain injury? ___ No ___ Yes ___ Unknown
15.	Did you have seizures or epilepsy prior to the traumatic brain injury? ___ No ___ Yes ___ Unknown
16.	Were you 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
17.	Date of diagnosis: _____
18.	Who gave this diagnosis? ___ Neurosurgeon ___ Neurologist ___ Pediatric Neurologist ___ Primary Care Physician ___ Pediatrician ___ Psychiatrist ___ Psychologist ___ Nurse Practitioner
19.	Have you received medication for seizures or epilepsy? ___ No - never ___ Yes – Pre-injury only ___ Yes – Post injury but not currently ___ Yes – Currently ___ Unknown
20.	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:_____
21.	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
22.	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
23.	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
24.	In the last month, did you 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 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

25.	Ask everyone, regardless of the answer above: 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
25a.	Ask everyone, regardless of the answer above: 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
26.	**Skip this question if question #24 = no (even if question #25=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. 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 you have used to get high (Specify:_____)
27.	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

28.	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
29.	Are you or were you involved in litigation due to your injury? ___ No ___ Yes, suing another party or insurance company ___ Yes, defendant in lawsuit ___ Both suing and defendant ___ Unknown
30.	If you are not presently involved in litigation, are you planning on being involved? ___ No ___ Yes, planning on suing another party or insurance company ___ Yes, will probably be a defendant ___ Yes, both suing and defendant ___ Unsure ___ Other: _____ ___ Unknown
31.	If involved, have you received any settlement? ___ No ___ Yes ___ Not involved ___ 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

34.	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)
34a.	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
34b.	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
34c.	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
34d.	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
34e.	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

34f.	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
34g.	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
34h.	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
34i.	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

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: _____

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

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 (0 1②3 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⊗3④). 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

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:_____

Rivermead Post Concussion Symptoms Questionnaire*

Modified (RPQ-3 and RPQ-13)

After a head injury or accident some people experience symptoms that can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below please circle the number that most closely represents your answer.

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

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

	not experienced	no more of a problem	mild problem	moderate problem	severe problem
Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity (easily upset by loud noise)	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred vision	0	1	2	3	4
Light sensitivity (easily upset by bright light)	0	1	2	3	4
Double vision	0	1	2	3	4
Restlessness	0	1	2	3	4

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:_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

DATE ADMINISTERED:_____ SUBJECT ID:_____

Patient Health Questionnaire (PHQ-9)

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:_____

Social Isolation –Short Form 4a

Please respond to each item by marking one box per row.

		Never	Rarely	Sometimes	Usually	Always
UCLA11x2	I feel left out.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UCLA13x3	I feel that people barely know me.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UCLA14x2	I feel isolated from others	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UCLA18x2	I feel that people are around me but not with me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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_____

Insomnia Severity Index

For each question, please CIRCLE the number that best describes your answer.

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

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

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

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

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

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

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

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

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

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

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:_____

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version - Past Month

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* 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) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?* (If yes to either part of 5, mark YES.)		

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* 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: *Was this within the past three months?***	**YES**	**NO**

- 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.

DATE ADMINISTERED:_____ SUBJECT ID:_____

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):

TRACK-TBI LONG

Telephone

Case Report Forms

Informants

DATE ADMINISTERED:_____ SUBJECT ID:_____ START TIME:_____

Has the subject died? Circle one. *No* *Yes*

Functional Status Examination

Traumatic Brain Injury Studies
University of Washington

Contact Information:
Sureyya Dikmen, Ph.D.
Rehabilitation Medicine, Box 359612
325 Ninth Avenue
University of Washington | Seattle, WA 98104
Phone: (206) 685-7529, Fax: (206) 897-4881
E-mail: dikmen@u.washington.edu

DATE ADMINISTERED:_____ SUBJECT ID:_____

Personal Care

I am now going to ask you about your personal care activities. This refers to bathing, getting in/out of the tub or shower, shaving, brushing your teeth or hair, going to the bathroom, dressing or eating. After an injury, you may get help with one or more of these activities. For example, someone might help you bathe, dress, or help feed you or cut your food.

Due to your injury, is anyone helping you more now with your personal-care activities?

YES		***NO***		
Does someone help you with almost all of your important personal care needs, or just some?		Is there any *important* personal-care activity that you have stopped doing or that you are doing less often than before?		
ALMOST ALL	***JUST SOME***	***YES***	***NO***	
What are you getting help with? Explain.	What are you getting help with? Explain.	Explain.	Are you having more difficulty taking care of your personal care needs due to injury? Are you any slower, or less capable for any reason, including pain or feeling uncomfortable? Do you have more difficulty chewing or swallowing? Have problems with your memory, how you feel or any other changes made any of your personal care activities more difficult?	
			YES	***NO, SAME AS BEFORE***
			Explain.	
CODE 3	***CODE 2***		***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

Mobility/Ambulation

Now I am going to ask you some questions about your ability to get around in your home, yard or within a few blocks of your home with or without a cane, walker or wheelchair.

Due to your injury, are you unable to get from place to place within your immediate environment? Are other people helping you more now?? For example, does someone else push your wheelchair, hold onto you, guide you, go with you or help you get around at least part of the time (e.g., when you are outside, on uneven ground, or getting in or out of your bed or chair)?

YES		***NO***			
Are you almost always unable to get from place to place or is someone almost always with you or just some of the time?		Is getting around within your immediate environment restricted? Are you avoiding stairs, the outdoors, slopes, uneven ground, hills, etc.? (Include independent wheelchair users.)			
YES, ALMOST ALWAYS	***NO, JUST SOME***	***YES, RESTRICTED***	***NO***		
Explain.	What kind of help are you getting?	Explain.	Is getting from place to place more difficult for you now in any way due to your injury? Are you slower? Do you rest more often, tire more easily, or walk with an uneven gait or limp? Are you more unsteady? Have any other changes related to the injury made walking more difficult for you now?		
			YES		***NO, SAME AS BEFORE***
			Explain.		
CODE 3	***CODE 2***		***CODE 1***		***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

Mobility/Travel

The next questions have to do with your ability to get to places beyond a few blocks of your home (i.e., driving, riding a bus, train or taking a taxi or another way to get from place to place).

Due to your injury, is anyone helping you more now with transportation outside of your immediate environment? For example, is someone driving you places more often (e.g., during rush hour, long distances, when it is dark, in the city, etc.), or is someone going with you more often when you travel away from home?

YES		***NO***		
Is someone always with you when you travel or just some of the time)?		Is travel more limited now due to the injury? Are you driving less frequently or not going certain places? Are you avoiding driving at night, in bad weather, in the city, or in heavy traffic? Are you more limited to the bus train, taxi, etc.?		
YES, ALWAYS (Includes Non-Mobile Individuals)	***NO, JUST SOMETIMES***	***YES***	***NO***	
Explain.	When and how does someone help you?	Explain.	Is traveling from place to place more difficult for you now due to your injury? Are you less sure of yourself or more nervous? Are problems with vision, reaction time, coordination or strength, etc. making it more difficult? Have any other changes related to the injury made it more difficult to drive or get to where you need to be?	
			YES	***NO, SAME AS BEFORE***
			Explain.	
CODE 3	***CODE 2***		***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

If 1 or more of the following 3 questions = yes, administer this category
Pre-injury worker: 1=Yes 0=No
Worker now: 1=Yes 0=No
Would have been a worker now if not for the injury: 1=Yes 0=No 2=N/A
Work is primary: 1=Yes 0=No

Work

This section is about being self-employed, family-employed, or employed competitively by someone else.

Are you currently working?

NO, NOT WORKING DUE TO INJURY	***YES Working (or if not working and it's not due to the injury then ask the following questions hypothetically)***		
Explain.	Compared to your pre-injury work, are you currently earning less money (at least 25% less), or are you in a job which has less responsibility due to the injury? Have you received a demotion? Have you reduced your work hours by 25% or more? Is someone taking over any of your previous job duties?		
	YES	***NO***	
	Explain.	Are you having difficulty on the job now due to the injury? Is it taking you longer to get things done? Are problems with fatigue, concentration, memory, how you feel, or pain making your job harder? Are you having more trouble getting along with people at your job? Have you reduced your hours by <25%, or are you taking more days off from work due to your health? Do any other problems make work more difficult?	
		YES	***NO, SAME AS BEFORE***
		Explain.	
CODE 3	***CODE 2***	***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

If 1 or more of the following 3 questions = yes, administer this category
Pre-injury student: 1=Yes 0=No
Student now: 1=Yes 0=No
Would have been a student now, or had to drop out due to the injury: 1=Yes 0=No 2=N/A
School is primary: 1=Yes 0=No

School

This means classes taken for academic credit in a formal academic setting.

Are you currently attending school?

NO, NOT IN SCHOOL DUE TO INJURY	***YES in school (or if not in school and it's not due to the injury ask the following questions hypothetically)***		
Explain.	Compared to your pre-injury school, are you now taking fewer classes, easier classes or are you enrolled in an easier school due to your injury? Are you receiving extra help from others (e.g. note-taker, tutor, parents, etc.) to help you keep up your grades? Are you failing classes that you wouldn't have failed before?		
	YES	***NO***	
	Explain.	Are you having more difficulty with your classwork? Does it take you longer? Are you performing poorer? Are problems with memory, fatigue, or concentration making it more difficult for you now? Are you taking more time off? Do any other problems interfere with school?	
		YES	***NO, SAME AS BEFORE***
		Explain.	
CODE 3	***CODE 2***	***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

Home Management

The next questions are about your usual home care activities including cleaning, cooking, laundry, shopping, yard-care, car-care, home repair, home maintenance and childcare.

What were your normal home management responsibilities pre-injury?	**Living Situation**
	Pre-Injury:
	Post-Injury:

What are your home management responsibilities now?

Due to your injury, is anyone helping you more now with your usual home-care tasks or is someone else doing any of the home-care activities that you did before?

YES		***NO***		
Is someone else doing almost all of your usual home-care tasks or just some?		Are there any important home-care activities that you are avoiding now or performing less frequently than before due to the injury? Is there anything that you are not doing now?		
ALMOST ALL	***JUST SOME***	***YES***	***NO***	
Explain.	Explain.	Explain.	Is it harder for you to do any of your home-care activities now? Do you stop to rest more often? Are you slower, less capable for any reason, including pain or feeling uncomfortable? Do any other problems related to the injury interfere with your home management?	
			YES	***NO, SAME AS BEFORE***
			Explain.	
CODE 3	***CODE 2***		***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

Leisure and Recreation

The next questions are about what you like to do for fun during your free time like playing or watching sports, going to the movies, playing or listening to music, dancing, watching TV, reading, etc.

What did you do for fun pre-injury?

What do you do for fun now?

Due to your injury, have you dropped any of your usual fun activities, or are you receiving more help from anyone in order to continue to do them? Does anyone go with you more now while doing your fun activities, or drive you places so that you may do them?

YES		***NO***	
Have you dropped nearly all of your previous fun activities, or just some of them? Does someone always go with you or help you when doing those activities, or do they help you some of the time?		Are there any fun activities that you are performing less frequently or for shorter periods of time now due to your injury?	
ALMOST ALL	***DROPPED OR IS HELPED WITH <u>ONLY</u> <u>SOME</u> ACTIVITIES***	***YES***	***NO***
Explain.	Explain.	Explain.	Are your fun activities more difficult for you now due to your injury? Do you tire more easily, lose your balance, lose concentration, or perform them less capably for any reason? Do any other changes related to the injury make doing your leisure activities more difficult?
			YES / Explain. / ***NO, SAME AS BEFORE***
CODE 3	***CODE 2***		***CODE 1*** / ***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

DATE ADMINISTERED:_____ SUBJECT ID:_____

Social Integration

Now I will ask you questions about your social relationships.

Who did you live with pre-injury?

Who do you live with now?

Due to your injury, are your social interactions more limited now? For example, do you have fewer friends now, less contact with friend and family, or are you spending less time with family or friends? Are you losing friends or having a harder time making new friends?

YES		***NO***		
Are your social interactions limited only to parents, *immediate* family, or to those where you live, due to the injury?		In order to maintain your prior social interaction, do you have to rely more on others? Are others going with you or driving you in order to socialize?		
YES, SOCIALLY ISOLATED	***NO, ONLY PARTIALLY LIMITED (i.e. fewer friends, less contact with friends, family, or less able to make new friends)***	***YES***	***NO***	
Explain.	Explain.	Explain.	Are you having more difficulty getting along with your friends and family due to the injury? Are your relationships more tense, awkward or less satisfying? Do any other changes related to the injury interfere with your socializing?	
			YES	***NO, SAME AS BEFORE***
			Explain.	
CODE 3	***CODE 2***		***CODE 1***	***CODE 0***

(If code is higher than 0), how much do these difficulties bother you in your day-to-day life?	**None = 0**	**Mild = 1**	**Moderate = 2**	**Severe = 3**

Functional Status Exam (FSE)

What factors have contributed to the rating of the FSE (check all that apply):

- ☐ Study Injury
- ☐ New Injury: (specify)_____
- ☐ New or Worsened Neurological Condition:(specify)_____
- ☐ New or Worsened Mental Health Issues: (specify): _____
- ☐ Other: (specify): _____

☐ Not Applicable (No issues identified on the FSE)

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.

What factors have contributed to the rating of the GOSE (check all that apply):

- ☐ Study Injury
- ☐ New Injury: (specify)_____
- ☐ New or Worsened Neurological Condition:(specify)_____
- ☐ New or Worsened Mental Health Issues: (specify): _____
- ☐ Other: (specify): _____
- ☐ Not Applicable (Final rating = 8)

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)	**GOS-E SCORE:**	
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)		

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.

Relationship to participant……..

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

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 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 _____(participant with TBI)? ____ Very well ____ Fairly well ____ Not well (Specify when and how the informant has been in contact with the study participant): _____
	Gardner Motor/Parkinsonism/Neurodegenerative Disease Screen
4a.	Compared to before his/her study injury, does he/she currently have difficulty with any aspect of movement or walking such as: tremors or shaking of arms or legs, smaller handwriting, difficulty buttoning clothes, softer or quieter voice, reduced facial expression, shuffling feet or taking tiny steps when walking, poor balance leading to falls or near-falls, difficulty with coordination of hands or arms or legs, or overall slowness of movement? ___ Yes; new symptom(s) now not present pre-injury ___ Yes; symptom(s) present pre-injury but worse now ___ No; symptom(s) never present or present pre-injury but not worse now (N/A for 4b, go to 4c) ___ Unknown

4b.	Is this difficulty with movement or walking overall BETTER, WORSE, or ABOUT THE SAME since his/her last study visit? *[Note: If multiple movement/walking symptoms are endorsed then any worsening symptom takes precedence]* ___ Much Better ___ Better ___ About the same ___ Worse ___ Much Worse ___ Unknown
4c.	Has he/she ever been told by a health care provider that he/she has Parkinson's disease, Mild Cognitive Impairment (MCI*), Alzheimer's disease (AD), any other type of dementia, or Lou Gehrig's disease/ALS? *MCI is defined by PROGRESSIVELY WORSENING deficits in memory or thinking that do not yet significantly impact daily functioning ___ Yes ___ No ___ Unknown If yes, circle which may apply: Parkinson's disease, Mild Cognitive Impairment (MCI), Alzheimer's disease (AD), any other type of dementia, Lou Gehrig's disease/ALS
4d.	Do you think he/she may have Parkinson's disease, Mild Cognitive Impairment (MCI), Alzheimer's disease (AD), any other type of dementia, or Lou Gehrig's disease/ALS? ___ Yes ___ No ___ Unknown If yes, circle which may apply: Parkinson's disease, Mild Cognitive Impairment (MCI), Alzheimer's disease (AD), any other type of dementia, Lou Gehrig's disease/ALS
	If the Informant did not know the subject during the subject's participation in TRACK-TBI U01, skip all parts of this question. *"Now I would like to ask you how you think he/she is doing in 4 general areas, compared to how he/she was doing since their last assessment with us. For each area I am interested in whether you think he/she is overall BETTER, WORSE, or ABOUT THE SAME since their last study visit."*
5a.	In the area of taking care of self and basic needs at home, like eating using the bathroom,, getting bathed and dressed and ready for the day, is he/she MUCH BETTER, BETTER, ABOUT THE SAME, WORSE or MUCH WORSE since the last study visit? ___ Much Better ___ Better

	___ About the same ___ Worse ___ Much Worse ___ Unknown
5b.	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, is he/she MUCH BETTER, BETTER, ABOUT THE SAME, WORSE or MUCH WORSE since the last study visit? ___ Much Better ___ Better ___ About the same ___ Worse ___ Much Worse ___ Unknown
5c.	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, is he/she MUCH BETTER, BETTER, ABOUT THE SAME, WORSE or MUCH WORSE since the last study visit? ___ Much Better ___ Better ___ About the same ___ Worse ___ Much Worse ___ Unknown Confounding issues not addressed by the Test Completion Codes (i.e., behavioral observations, sedation medications, etc):
5d.	In the area of emotional function, like managing mood, getting along with others, and dealing with everyday stress, is he/she MUCH BETTER, BETTER, ABOUT THE SAME, WORSE or MUCH WORSE since the last study visit? ___ Much Better ___ Better ___ About the same ___ Worse ___ Much Worse ___ 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.

DATE ADMINISTERED:_____ SUBJECT ID:_____

TRACK-TBI LONG Informant Interview

Fill out only if not completing remaining questions with informant

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):

6a.	Has he/she sustained another traumatic brain injury since his/her study injury? ____ No – skip to #6f ____ Yes once ____ Yes more than once ____ Unknown – skip to #6f
6b.	Did he/she sustain any new traumatic brain injury due to falling? ____ No ____ Yes once ____ Yes more than once ____ Unknown
6c.	Did any of the new traumatic brain injuries involve loss of consciousness? ____ No ____ Yes once ____ Yes more than once ____ Unknown
6d1.	Was he/she admitted to the ICU for any of the new traumatic brain injury(ies)? ___ No (go to #6d2) ___ Yes, once (go to #6e) ___ Yes, more than one time (go to #6e) ___ Unknown (go to #6d2)
6d2.	Was he/she admitted to hospital but not to ICU for any of the new traumatic brain injury(ies)? ____ No (go to #6d3) ____ Yes, once (go to #6e) ____ Yes, more than one time (go to #6e) ____ Unknown (go to #6d3)
6d3.	Was he/she treated and released from the ED, Dr. office or other outpatient service for any of his/her new traumatic brain injury(ies)? ____ No ____ Yes, once ____ Yes, more than one time ____ Unknown
6e.	Are there current difficulties in his/her daily life due to the new traumatic brain injury(ies)? ____ No ____ Yes; Specify_____ ____ Unknown; Explain _____

6f.	Did he/she sustain any peripheral injuries (injuries to other parts of the body) since his/her study injury? ____ No (skip to 6i) ____ Yes one time ____ Yes, more than one time ____ Unknown (skip to 6i)
6g1.	Was he/she admitted to the ICU for any of the new peripheral injuries? ____ No (go to #6g2) ____ Yes, once (go to #6h) ____ Yes, more than one time (go to #6h) ____ Unknown (go to #6g2)
6g2.	Was he/she admitted to the hospital but not to the ICU for any of the new peripheral injuries? ____ No (go to #6g3) ____ Yes, once (go to #6h) ____ Yes, more than one time (go to #6h) ____ Unknown (go to #6h)
6g3.	Was he/she treated and released from the ED, Dr. office or other outpatient service for any of his/her new peripheral injuries? ____ No ____ Yes, once ____ Yes, more than one time ____ Unknown
6h.	Are there current difficulties in his/her daily life due to the new peripheral injury(ies)? ____ No ____ Yes ____ Unknown
6i.	Has he/she experienced any other new medical issues or illnesses since his/her 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

7a.	Current Marital Status (**choose one**) ___ Never married ___ Married ___ Domestic Partnership ___ Divorced ___ Separated ___ Widowed ___ Unknown
7b.	If there is a change in marital status since his/her study injury, is this related to his/her study injury? ___ No ___ Yes: comment_____ ___ N/A no change in marital status since the study injury ___ Unknown
8.	Living situation/residence. Where is he/she 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
9.	If there has been a change in his/her 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#6 of this interview ___ Financial problems related to the study injury ___ Financial problems unrelated to the study injury ___ Other:_____ ___ N/A – no change ___ Unknown
10a.	What is his/her 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
10b.	If he/she is 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#6 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

[**Skip question for Trauma Controls and Friend Controls]**

11. For TBI participants: Has he/she seen any healthcare provider (e.g., doctor, psychologist, rehabilitation therapist) since his/her last study visit for his/her traumatic brain injury (his/her study brain injury)?

___ No

___ Yes

___ Unknown

If yes, what type of healthcare provider (check all that apply), and what type of appointment was it?

Type of healthcare provider Indicate below for each healthcare provider: 1 = No, 2 = Yes 1 time, 3 =Yes, 2-5 times, 4 = Yes, 6 or more times, 9 = Unknown	Type of appointment? (1 = Consult only, 2 = Treatment, 8 = N/A did not visit this healthcare provider; 9 = Unknown)
General practitioner (primary care) ___	
Brain injury/Concussion Clinic ___	
Neurologist ___	
Physiatrist (Rehab doctor) ___	
Chiropractor ___	
Psychiatrist ___	
Psychologist, Neuropsychologist, psychological services ___	
Alternative Medicine (acupuncture, massage, nutrition, herbal supplements, etc.) ___	
Neurosurgeon ___	
Pain Specialist ___	
Rehabilitation therapist (e.g., physical, occupational, or speech therapist) ___	
Other (specify):_____	

[Examiner: help the informant answer the following question by asking them to recall when the subject first received treatment and then when treatment ended (i.e., answer only if Type of Appointment = 2 "Treatment")]

How long did he/she receive outpatient treatment?

___ < 2 weeks

___ 2-4 weeks

	___ 5-8 weeks ___ 9-12 weeks ___ > 12 weeks ___ Active outpatient rehab ongoing ___ Annual check up ___ Unknown ___ N/A
	Caregiver Time
12a.	We need to understand difficulties people may have with various activities because of a health or physical problem. Please tell me whether he/she requires help doing everyday activities such as the following: getting across a room, dressing, bathing, eating, getting in/out of bed, using the toilet, preparing meals, shopping for groceries, making telephone calls, taking his/her medications, managing his/her money. ___ Never (skip to question #13) ___ Rarely ___ Sometimes ___ Most of the time ___ Always ___ Don't know (skip to question #13) ___ Refused
12b.	Do you think the amount of help he/she needs has increased since his/her last study visit? ___ No ___ Yes ___ Unknown
12c.	Who ***most often*** helps him/her with these tasks? ___ Spouse/partner ___ Child ___ Other family member ___ Friend ___ Volunteer or other unpaid ___ Home health care worker ___ Employee of the place where he/she lives ___ Other paid ___ Don't know ___ Refused

	Epilepsy Screening
13.	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 he/she had any of the following?
13a.	Uncontrolled movements of part or all of his/her body such as twitching, jerking, shaking, or going limp, lasting about 5 minutes or less? ___ No ___ Yes ___ Unknown
13b.	An unexplained change in mental state or level of awareness; or an episode of "spacing out" which he/she could not control, lasting about 5 minutes or less? ___ No ___ Yes ___ Unknown
13c.	Any other type of repeated unusual attacks or convulsions lasting about 5 minutes or less? ___ No ___ Yes ___ Unknown
14.	Has anyone ever told him/her that he/she has seizure(s) or epilepsy? ___ No ___ Yes ___ Unknown
	If 1 or more of questions 13a, 13b, 13c or 14 = yes then ask questions 15 – 20. If 13a – 14 are each = no then skip question 15 – 20 and go to question 21.
15.	Did the most recent seizure(s) occur later than 7 days after the date of the traumatic brain injury? ___ No ___ Yes ___ Unknown
16.	Did he/she have seizures or epilepsy prior to the traumatic brain injury? ___ No ___ Yes ___ Unknown

17.	Was he/she diagnosed with epilepsy, a seizure disorder, or a single seizure after the date of the traumatic brain injury diagnosis? ___ No (skip to Q20) ___ Yes ___ Unknown
18.	Date of diagnosis: _____
19.	Who gave this diagnosis? ___ Neurosurgeon ___ Neurologist ___ Pediatric Neurologist ___ Primary Care Physician ___ Pediatrician ___ Psychiatrist ___ Psychologist ___ Nurse Practitioner
20.	Has he/she received medication for seizures or epilepsy? ___ No - never ___ Yes – Pre-injury only ___ Yes – Post injury but not currently ___ Yes – Currently ___ Unknown
21.	Does he/she 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:_____

22.	How often does he/she 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
23.	How many drinks containing alcohol does he/she have on a typical day when he/she is 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
24.	How often does he/she 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
25.	In the last month, did he/she 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 he/she might have inhaled or 'huffed'. We also want to know if sometimes he/she took more than he/she should have of any drugs that have been prescribed to him/her.'' ___ No ___ Yes ___ Unknown

26.	Ask everyone, regardless of the answer above: Did he/she use Marijuana? ___ No (If the answer is 'YES" then ask, 'Was Marijuana prescribed to him/her) ___ 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
26a.	Ask everyone, regardless of the answer above: Did he/she 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
27.	**Skip this question if question #25 = no (even if question #26=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. 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 he/she has used to get high (Specify:_____)
28.	Since his/her last study visit has he/she 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

29.	The next question asks about using prescription pain relievers in any way a doctor did not direct him/her 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 his/her use of the drug in any way a doctor did not direct him/her to use it, including: using it without a prescription of his/her own, using it in greater amounts, more often, or longer than he/she was told to take it, using it in any other way a doctor did not direct him/her to use it. In the past 12 months, has he/she ever, even once, used any prescription pain reliever in any way a doctor did not direct him/her to use it? ___ No ___ Yes ___ Unknown
30.	Is he/she or was he/she involved in litigation due to his/her injury? ___ No ___ Yes, suing another party or insurance company ___ Yes, defendant in lawsuit ___ Both suing and defendant ___ Unknown
31.	If he/she is not presently involved in litigation, is he/she 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
32.	If involved, has he/she received any settlement? ___ No ___ Yes ___ Not involved ___ Unknown

33.	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
34.	During the last year, how much money did he/she receive from wages or salary, tips, commissions, or bonuses, or his/her 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

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: _____

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

END TIME _____