BRAIN INJURY SCREENING

If a person/child has experienced a blow to the head, with or without a loss of consciousness, the possibility of a brain injury and further cognitive and/or neuropsychological evaluation should be considered. This is a brief screening device for traumatic or acquired brain injury to evaluate whether a person/child may have experienced a brain injury. Nearly 1 million brain injuries occur every year in the United States, but some people may not realize that they experienced a brain injury. Correctly evaluating a person/child for brain injury helps determine their service needs.

Name (Last) ___________________________ (First) ___________________________ (MI) __________

Program ID, if any ___________________________ If child, school grade level __________

DOB □□□□-□□-□□□□ SSN, with consent □□□□-□□□□-□□□□

Gender □M □F Known Injury? □Yes □No Date of Injury □□□□-□□-□□□□ Lost Consciousness? □Yes □No

If Loss of Consciousness, Duration (check only one) □ None □ Less than 1 minute □ 1-15 minutes

□ 16 minutes to 1 hour □ 1 hour to 24 hours □ 25 hours to 7 days □ 8 days to one month

□ 1 to 3 months □ 4 to 12 months □ More than one year □ Unknown

Present Mobility □ Bedridden □ Wheelchair (frequent) □ Wheelchair (infrequent)

□ Walks with assistance □ Walks without assistance

INJURY HISTORY

Has the person/child ever --

□ Had a concussion? □ Yes □ No

□ Been in a car/van/truck/bus crash? □ Yes □ No

□ Had "whip lash" injury? □ Yes □ No

□ Been in a motorcycle or an all-terrain vehicle crash? □ Yes □ No

□ As a pedestrian, been hit by a vehicle? □ Yes □ No

Has the person/child ever been hit on the head --

□ By equipment or a falling object? □ Yes □ No

Has the person/child ever been hit on the head when falling --

□ On a level surface? □ Yes □ No

□ Down stairs? □ Yes □ No

□ From a high place? □ Yes □ No

□ During a fainting spell? □ Yes □ No

□ As a result of using drugs or alcohol? □ Yes □ No

Has the person/child ever been hit on the head during a sports activity --

□ While bicycling, roller blading or skate boarding? □ Yes □ No

□ While horseback riding, skiing or snow boarding? □ Yes □ No

□ In team sports (football, baseball, basketball, soccer)? □ Yes □ No

□ While swimming or diving into water? □ Yes □ No

Has the person/child ever experienced a blow to the head as a result of --

□ Assault or mugging? □ Yes □ No

□ Fighting? □ Yes □ No

□ Physical abuse? □ Yes □ No

□ Being shaken as a baby? □ Yes □ No

□ Other cause of a blow to the head? □ Yes □ No Specify ___________________________

(OVER)
BRAIN INJURY SCREENING CONTINUED

MEDICAL HISTORY Has the person/child ever been in the hospital, seen in an emergency room or by a doctor for any of the following reasons?

- Concussion  □ Yes □ No  Fracture of the head, neck or face  □ Yes □ No
- Seizure(s) □ Yes □ No  Near drowning □ Yes □ No
- Episode(s) of Anoxia □ Yes □ No  Loss of consciousness □ Yes □ No
- Electrical power injury □ Yes □ No  Lightening strike □ Yes □ No
- Gun shot injury to the head □ Yes □ No  Other penetrating injury to the head □ Yes □ No
- Brain infection or tumor □ Yes □ No  Stroke or brain hemorrhage □ Yes □ No
- Other medical emergency □ Yes □ No  Specify ______________

If a person/child has one or more of these experiences, the possibility of a brain injury and further cognitive and/or neuropsychological evaluation should be considered.

PROBLEMS OR DIFFICULTIES EXPERIENCED IN DAILY LIVING

- Trouble staying awake? □ Yes □ No  Difficulty concentrating? □ Yes □ No
- Trouble sleeping? □ Yes □ No  Problems with memory? □ Yes □ No
- Frequent headaches? □ Yes □ No  Difficulty reading, writing, or calculating? □ Yes □ No
- Dizziness? □ Yes □ No  Difficulty performing assignments at school or work? □ Yes □ No
- Blackouts? □ Yes □ No  Difficulty with physical coordination? □ Yes □ No
- Seizures? □ Yes □ No  Blurred or double vision? □ Yes □ No
- Problems with balance? □ Yes □ No  Difficulty with relationships? □ Yes □ No
- Difficulty problem solving? □ Yes □ No  Unusual fatigue? □ Yes □ No
- Unusual anxiety? □ Yes □ No  Difficulty following instructions? □ Yes □ No
- Depression? □ Yes □ No  Altered sensitivity to light or sound? □ Yes □ No
- Difficulty planning events? □ Yes □ No  Altered sensitivity to heat or cold? □ Yes □ No
- Unusual irritability or anger? □ Yes □ No  Problems with being in crowded places? □ Yes □ No
- Do friends or family seem unfamiliar? □ Yes □ No  Changes in taste or smell? □ Yes □ No
- Unusually intense emotions? □ Yes □ No  Difficulty organizing tasks or schedule? □ Yes □ No
- Altered hearing? □ Yes □ No  Difficulty managing/handling money? □ Yes □ No
- Changes to appetite or eating habits? □ Yes □ No
- Difficulty with speech or swallowing? □ Yes □ No

If a person/child has experienced some of these difficulties, the possibility of a brain injury and further cognitive and/or neuropsychological evaluation should be considered.

OTHER OBSERVATIONS OR REMARKS

Does the person/child/child’s parent wish to receive additional information about brain injury? □ Yes □ No

If yes, more information is available from:
Texas Traumatic Brain Injury Advisory Council
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756

www.tdh.state.tx.us/braininjury
brain.injury@tdh.state.tx.us
512/458-7111, ext. 3069

Screen Completed By ________________________________

Screener Telephone Number __________________________

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(Identification information on reverse)