Name/Code: _____ Date Received: _____

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Brain Check Survey

Parent/Guardian Version

Student Information

Today's Date: ___/___/___ Child's Age: _____

Child's Date of Birth: ___/___/___ Child's Gender: ☐ Male ☐ Female

Child's race: (circle one or more)	1: American Indian/Alaska Native 2: Asian 3: Native Hawaiian or Other Pacific Islander	4: Black or African American 5: White 6: More than one race Please describe:_____

Child's ethnicity: (circle one)	1: Hispanic or Latino 2: Not Hispanic or Latino	3: Unknown or Not Reported

Injuries or Illnesses

Injury or Illness	Age	Outcomes
Please check all that apply		
☐ **Blow to Head** (from sports, playing, biking, falling, getting hit by an object, etc.)	At what age?____	Check all that apply: ☐ Concussion ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem
☐ **Whiplash**	At what age?____	Check all that apply: ☐ Concussion ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem
☐ **Car accident** (resulting in any degree of injury or lack of injury)	At what age?____	Check all that apply: ☐ Concussion ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem

Name/Code: _____

Injury or Illness	Age	Outcomes
Please check all that apply		
☐ **Assault/Violence (child abuse, fights, firearm injury)**	At what age?____	Check all that apply: ☐ Concussion ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem
☐ **Sustained High Fever**	At what age?____	Check all that apply: ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem
☐ **Brain Tumor**	At what age?____	Check all that apply: ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem
☐ **Anoxia** (definition: lack of oxygen; caused by such events as a near-drowning experience or suffocating experience)	At what age?____	Check all that apply: ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem
☐ **Meningitis**	At what age?____	Check all that apply: ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem
☐ **Encephalitis**	At what age?____	Check all that apply: ☐Loss of consciousness, *for how long?_____ ☐Coma, *for how long? _____ ☐Confusion or altered mental state ☐Missed school ☐ Resulted in no problem
☐ **Seizures** (example: epilepsy)	At what age?____	Check all that apply: ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem

Name/Code: _____

Injury or Illness	Age	Outcomes
Please check all that apply		
☐ **Overdose of** drugs or alcohol, or inappropriate use of prescription drugs or over-the-counter medication?	At what age?____	Check all that apply: ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem
☐ **Other:** _____ _____	At what age?____	Check all that apply: ☐ Concussion, *for how long? _____ ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem
☐ **Other:** _____ _____	At what age?____	Check all that apply: ☐ Concussion, *for how long? _____ ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem

Has your child ever been to the emergency department? ☐ *Yes* ☐ *No*
If YES, at what age?_____ Please explain:

Behaviors that can affect learning

Please tell us about your child's learning styles and behaviors

Learning Style or Behavior	Not Applicable? (check)	Circle the number on the scale which best describes your child: No Problem ⟺ Extreme Problem					
	☐ N/A	**1**	**2**	**3**	**4**	**5**	**6**
Focusing and maintaining attention	☐ N/A	1	2	3	4	5	6
Getting started on activities, tasks, chores, homework and the like, on his or her own	☐ N/A	1	2	3	4	5	6
Being understood (speech is easy to understand, speaks clearly)	☐ N/A	1	2	3	4	5	6
Understanding others	☐ N/A	1	2	3	4	5	6
Coping with change or transitions	☐ N/A	1	2	3	4	5	6
Maintaining family and friend relationships	☐ N/A	1	2	3	4	5	6
Letting go of one activity to attend to another	☐ N/A	1	2	3	4	5	6
Reaction to simple problems	☐ N/A	1	2	3	4	5	6

Name/Code: _____

Learning Style or Behavior	Not Applicable? (check)	Circle the number on the scale which best describes your child: No Problem ⟺ Extreme Problem
Monitoring own progress on homework, assignments, chores, and the like	☐ N/A	1 2 3 4 5 6
Solving everyday problems (example: thinking of different options when something is not working for him/her.)	☐ N/A	1 2 3 4 5 6
Waiting for his or her turn in a game	☐ N/A	1 2 3 4 5 6
Learns from past mistakes or behavior	☐ N/A	1 2 3 4 5 6
Thinks before speaking or acting	☐ N/A	1 2 3 4 5 6
Listens without interrupting others often	☐ N/A	1 2 3 4 5 6
Handles a change in plans	☐ N/A	1 2 3 4 5 6
Demonstrates good judgment	☐ N/A	1 2 3 4 5 6
Learns new things easily	☐ N/A	1 2 3 4 5 6
Remembers lists	☐ N/A	1 2 3 4 5 6
Remembers day-to-day events	☐ N/A	1 2 3 4 5 6

Symptoms

If your child has experienced any of the following symptoms, rank the severity of those symptoms.

Please check all that apply:

Symptom	Not Applicable? (check)	Circle the number on the scale which best describes your child: No Problem ⟺ Extreme Problem
	☐ N/A	**1 2 3 4 5 6**
Headaches and/or Migraines (sudden, not responsive to medications, can last for more than a day)	☐ N/A	1 2 3 4 5 6
Loss of muscle coordination (can look like awkward movements, problems with balance, slowed reactions, uncoordinated running and catching)	☐ N/A	1 2 3 4 5 6
Blackouts/ Fainting	☐ N/A	1 2 3 4 5 6
Confusion	☐ N/A	1 2 3 4 5 6
Blank staring/Day dreaming	☐ N/A	1 2 3 4 5 6
Dizziness	☐ N/A	1 2 3 4 5 6
Change in vision (blurred vision, double vision, depth perception)	☐ N/A	1 2 3 4 5 6
Fatigue (tires easily, is often tired)	☐ N/A	1 2 3 4 5 6
Seizures	☐ N/A	1 2 3 4 5 6
Slurred speech	☐ N/A	1 2 3 4 5 6
Has trouble finding the “right” word when talking	☐ N/A	1 2 3 4 5 6
Noise sensitivity (can be easily upset by loud noises or specific sounds like a ticking clock.)	☐ N/A	1 2 3 4 5 6

Name/Code: _____

Symptom	Not Applicable? (check)	Circle the number on the scale which best describes your child: No Problem ⟺ Extreme Problem
Light sensitivity (can be easily upset by bright or strobe lights)	☐ N/A	1 2 3 4 5 6
Sleepiness (has trouble staying awake during the day)	☐ N/A	1 2 3 4 5 6
Mood swings (unusual and/or quick changes between sadness, happiness, depression, anxiety, anger and the like; irritability)	☐ N/A	1 2 3 4 5 6

Educational Services

*Is your child having difficulties with school performance? Please describe:*_____

_____

*What does your child do best at in school? Please describe:*_____

_____

Is your child currently receiving any of the following services?

Check all that apply (If "yes", please check if they are provided through school and/or being provided privately).

Service	*Child's Status (please check)*
Occupational therapy	☐ **No** ☐ **Yes** If Yes, please check whether these services are delivered by: ☐ *school-supported specialists* (the school pays for the specialist); and/or ☐ *by private specialists* (you and/or your insurance pays)
Physical therapy	☐ **No** ☐ **Yes** If Yes, please check whether these services are delivered by: ☐ *school-supported specialists* (the school pays for the specialist); and/or ☐ *by private specialists* (you and/or your insurance pays)
Speech-Language therapy	☐ **No** ☐ **Yes** If Yes, please check whether these services are delivered by: ☐ *school-supported specialists* (the school pays for the specialist); and/or ☐ *by private specialists* (you and/or your insurance pays)
Other: _____	☐ **No** ☐ **Yes** If Yes, please check whether these services are delivered by: ☐ *school-supported specialists* (the school pays for the specialist); and/or ☐ *by private specialists* (you and/or your insurance pays)

Has your child ever been evaluated for special education services? ☐ YES ☐ NO

If Yes, at what age was your child first evaluated? _____

Does your child have a 504 plan? ☐ YES ☐ NO

If Yes, are the accommodations helping your child's school performance? ☐ YES ☐ NO

Name/Code: _____

Does your child have an IEP, Individualized Education Plan?

☐ **No**

☐ **Yes** → if YES, please answer 1 & 2 immediately below:

1. Is the IEP helping your child's school performance? ☐ YES ☐ NO
2. Please check all categories listed on the IEP:
   - ☐ Autism
   - ☐ Hearing Disability
   - ☐ Multiple Disabilities
   - ☐ Physical Disability - Conditions such as, but not limited to, attention deficit disorder, attention deficit hyperactivity disorder, and cerebral palsy may qualify as a physical disability
   - ☐ Pre-School Child with a Disability
   - ☐ Significant Identifiable Emotional Disability (SIED)
   - ☐ Specific Learning Disability (SLD)
   - ☐ Speech-Language Impairment
   - ☐ Significant Limited Intellectual Capacity (SLIC)
   - ☐ Traumatic Brain Injury (TBI)
   - ☐ Vision Disability
   - ☐ Other_____