Colorado State University
Department of Occupational Therapy
Life Outcomes after Brain Injury (LOBI) Research Program

Brain Check Survey

Available for use at: http://www.lobi.chhs.colostate.edu/index.aspx

To be filled out by the parent/guardian

Student/ Family Information

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

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

*Please answer the following questions about **YOURSELF:***
Are you the student's (circle all that apply)?

☐ Mother ☐ Father ☐ Foster Parent ☐ Other (ex: stepmother) please describe:_____

Your Name (printed): _____ Your Signature: _____

Contact information: Email _____ Phone _____

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:* ☐ Loss of consciousness, *for how long?_____ ☐ Coma, *for how long? _____ ☐ Confusion or altered mental state ☐ Missed school ☐ Resulted in no problem

Appendix D: Brain Check Survey

Injury or Illness *Please check all that apply*	Age	Outcomes
☐ **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
☐ **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

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Injury or Illness	Age	Outcomes
Please check all that apply		
☐ **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
☐ **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*: ☐ 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:* ☐ 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:

Appendix D: Brain Check Survey

Behaviors that can affect learning						
Please tell us about your child's learning styles and behaviors.						
Learning Style or Behavior	**Circle the number on the scale which best describes your child:**					
	No Problem					**Extreme Problem**
Coping with change or transitions	1	2	3	4	5	6
Maintaining family and friend relationships	1	2	3	4	5	6
Letting go of one activity to attend to another	1	2	3	4	5	6
Reaction to simple problems	1	2	3	4	5	6
Waiting for his or her turn in a game	1	2	3	4	5	6
Learns from past mistakes or behavior	1	2	3	4	5	6
Thinks before speaking or acting	1	2	3	4	5	6
Listens without interrupting others often	1	2	3	4	5	6
Handles a change in plans	1	2	3	4	5	6
Demonstrates good judgment	1	2	3	4	5	6

Cognitive processes that can affect learning						
Please tell us about your child's learning styles.						
Learning Style or Cognitive Processes	**Circle the number on the scale which best describes your child:**					
	No Problem					**Extreme Problem**
Focusing and maintaining attention	1	2	3	4	5	6
Getting started on activities, tasks, chores, homework and the like, on his or her own	1	2	3	4	5	6
Monitoring own progress on homework, assignments, chores, and the like	1	2	3	4	5	6
Solving everyday problems (example: thinking of different options when something is not working for him/her.)	1	2	3	4	5	6
Learns new things easily	1	2	3	4	5	6
Remembers lists	1	2	3	4	5	6
Remembers day-to-day events	1	2	3	4	5	6

Appendix D: Brain Check Survey

Symptoms- Part 1						
If your child has experienced any of the following symptoms, rank the severity of those symptoms. Please check all that apply:						
Symptom	**Circle the number on the scale which best describes your child:**					
	No Problem					**Extreme Problem**
Headaches and/or Migraines (sudden, not responsive to medications, can last for more than a day)	1	2	3	4	5	6
Blank staring/Day dreaming	1	2	3	4	5	6
Dizziness	1	2	3	4	5	6
Change in vision (blurred vision, double vision, depth perception)	1	2	3	4	5	6
Fatigue (tires easily, is often tired)	1	2	3	4	5	6
Light sensitivity (can be easily upset by bright or strobe lights)	1	2	3	4	5	6

Symptoms- Part 2						
If your child has experienced any of the following symptoms, rank the severity of those symptoms. Please check all that apply:						
Symptom	**Circle the number on the scale which best describes your child:**					
	No Problem					**Extreme Problem**
Loss of muscle coordination (can look like awkward movements, problems with balance, slowed reactions, uncoordinated running and catching)	1	2	3	4	5	6
Blackouts/ Fainting	1	2	3	4	5	6
Confusion	1	2	3	4	5	6
Seizures	1	2	3	4	5	6
Slurred speech	1	2	3	4	5	6
Has trouble finding the “right” word when talking	1	2	3	4	5	6