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 *Please check all that apply*	Age	Outcomes
☐ **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

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

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:

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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

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

Educational Services

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

____

____

____

____

____

____

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

____

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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 <u>Yes,</u> 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

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:
   - ☐Hearing Impairment, Including deafness
   - ☐Multiple Disabilities
   - ☐Deaf-Blindness
   - ☐Autism Spectrum Disorder
   - ☐Orthopedic Impairment
   - ☐Other Health Impaired
   - ☐Traumatic Brain Injury (TBI)
   - ☐Developmental Delay
   - ☐Serious Emotional Disability
   - ☐Intellectual Disability
   - ☐Specific Learning Disability
   - ☐Speech or Language Impairment
   - ☐Visual Impairment, Including Blindness