

# College Survey for Students with Brain Injury

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Name \_\_\_\_\_ Date \_\_\_\_\_

Interviewer \_\_\_\_\_

## I. Demographics

1. Please fill in the following:

(MM/DD/YYYY)

(1) Date of birth

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_

(2) Date of brain injury (please estimate if you are not certain)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_

2. Sex (circle)

Female      Male

3. Are you currently enrolled in college? (circle)

Yes              No

4. How many years (yrs) of college have you completed? (circle)

1yr    2yrs    3yrs    4 yrs    5yrs    6yrs    7+yrs

5. What years were you enrolled in college? (e.g. 2000-2004; 2006 to current)

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### II. Type of Brain Injury

6. What type(s) of brain injury do you have, and how old were you when each occurred?					
	Did you have this type of injury? (circle)		If yes, at what age? (circle)		
Traumatic brain injury (TBI)	Yes	No	0-11	12-17	18+
Stroke	Yes	No	0-11	12-17	18+
Brain tumor	Yes	No	0-11	12-17	18+
Multiple sclerosis (MS)	Yes	No	0-11	12-17	18+
Parkinson's disease (PD)	Yes	No	0-11	12-17	18+
Encephalitis	Yes	No	0-11	12-17	18+
Other (please specify) _____	Yes	No	0-11	12-17	18+

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### III. History of Injury

<b>Please tell us a little bit about your brain injury.</b>		
7. Please answer the following questions. If your answer is “yes,” please indicate a length of time.		
	Yes/ No/ Don't know (circle)	If yes, approximately how long? (circle)
Were you in the hospital after your injury?	Yes/ No/ Don't know	1 2 3 4 semester(s) 1 2 3 4 5 6 day(s) 1 2 3 week(s) 1 2 3 4 5 6 7 8 9 10 11 month(s) 1 year Ongoing NA Other
Were you unconscious or in a coma after your injury?	Yes/ No/ Don't know	1 2 3 4 semester(s) 1 2 3 4 5 6 day(s) 1 2 3 week(s) 1 2 3 4 5 6 7 8 9 10 11 month(s) 1 year Ongoing NA Other
Did you, or are you now receiving any therapy or rehabilitation after your injury?	Yes/ No/ Don't know	1 2 3 4 semester(s) 1 2 3 4 5 6 day(s) 1 2 3 week(s) 1 2 3 4 5 6 7 8 9 10 11 month(s) 1 year Ongoing NA Other

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Did you take a break from work or school after your injury?	Yes/ No/ Don't know	1 2 3 4 semester(s) 1 2 3 4 5 6 day(s) 1 2 3 week(s) 1 2 3 4 5 6 7 8 9 10 11 month(s) 1 year Ongoing NA Other
	Yes/ No/ Don't know (please circle)	If yes, approximately how long? (please circle)
Is brain injury your primary disability (Choose "N/A" for length of time)	Yes/ No/ Don't know	1 2 3 4 semester(s) 1 2 3 4 5 6 day(s) 1 2 3 week(s) 1 2 3 4 5 6 7 8 9 10 11 month(s) 1 year Ongoing NA Other
If you stated "other" for a length of time, please explain here. <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>		

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### IV. Effects of Brain Injury

	Experienced the effect	Had therapy for the effect
Difficulty with academics, like studying, homework, tests	<input type="checkbox"/>	<input type="checkbox"/>
Problems making decisions	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with relationships	<input type="checkbox"/>	<input type="checkbox"/>
Physical impairment: arm/hands (for example, writing, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Mood changes	<input type="checkbox"/>	<input type="checkbox"/>
Anger	<input type="checkbox"/>	<input type="checkbox"/>
Physical impairment: legs (for example, walking)	<input type="checkbox"/>	<input type="checkbox"/>
Substance/alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>
Memory problems	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Attention problems	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Organization problems	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty maintaining friendships	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)		
<div style="border-bottom: 1px solid black; height: 15px; width: 100%;"></div>		

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### V. Therapies for Brain Injury

8. Which of the following therapies have you received BECAUSE of your brain injury?			
	Please circle a response		
Psychological counseling	None	Past(completed)	Ongoing/current
Physical therapy	None	Past(completed)	Ongoing/current
Speech or language therapy	None	Past(completed)	Ongoing/current
Occupational therapy	None	Past(completed)	Ongoing/current
Support group	None	Past(completed)	Ongoing/current
Vocational counseling	None	Past(completed)	Ongoing/current
If "other," please specify			
<hr style="border: 0.5px solid black;"/> <hr style="border: 0.5px solid black;"/>			

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### VI. Your Student Experience

9. To what extent do you agree with each of the following statements about your experience as a college student since your brain injury?					
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
I forget what has been said in class.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get overwhelmed when studying.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get overwhelmed in class.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get nervous before tests.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have trouble managing my time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am late to class.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have trouble prioritizing assignments and meeting deadlines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others do not understand my problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I procrastinate on things I need to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have to review material more than I used to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I don't always understand instructions for assignments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have trouble paying attention in class or while studying.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have fewer friends than before.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in meeting other students with brain injury? Are you interested in getting help from an educational specialist in brain injury? Indicate "Yes" or "No" here.					
_____					
_____					

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### VII. Your Use of Services

10. Since you have been in college (or when you were in college) did you use the following services because of your brain injury?							
	Never heard or it	Heard of it but never used	Once	Occasionally	Sometimes	Pretty Often	All the time
Campus Disability Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Campus Veterans Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Campus Counseling Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Campus Medical Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A campus group for students with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State Brain Injury Association	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State vocational rehabilitation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other hospital or rehabilitation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "other," please specify; or write any other comments here.							



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### VIII. Rating Services

11. For any service that you have used at least once, please tell us how useful you found the service.					
	Completely useless	Somewhat useless	Somewhat useful	Extremely useful	N/A
Campus Disability Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Campus Veterans Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Campus Counseling Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Campus Medical Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A campus group for students with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State Brain Injury Association	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State vocational rehabilitation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other hospital or rehabilitation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "other," please specify; or write any other comments here.					

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### IX. Life Changes

12. Please tell us about changes you have made in your life plans, goals, work situation, etc. since your brain injury.	
Have you changed what college or university you attend? If yes, what did you change it from and to?	<hr/> <hr/> <hr/>
Have you changed your academic major? If yes, what was the change?	<hr/> <hr/> <hr/>
Have you changed your academic status (e.g. full-time vs. part-time)? If yes, what was the change?	<hr/> <hr/> <hr/>
Have you changed your career goal(s)? If yes, what was the change?	<hr/> <hr/> <hr/>
Have you changed where you live? If yes, what was the change?	<hr/> <hr/> <hr/>
Have you changed your current employment? If yes, what was the change?	<hr/> <hr/> <hr/>
Comments:	
<hr/> <hr/> <hr/>	