Interviewer_____ Unit _____ Date _____ Client ID _____

TBIQ (rev 10/02/2006)

Section I – Screening

Ask questions below to help jog the participant's memory. Jot answers beside each question and record the number of times. We are looking for mechanical induced brain injury rather than chemical. If the participant answers "yes" to any event, ensure that it involved a head injury and record the number of times the incident occurred in column labeled F (frequency). Record the details of relevant events (brain injury) in Section II. ***If the number of times provided for a specific injury type is > 5, record an estimate in column F and on the next page probe for 3 or 4 of the most severe instances of this type of injury.***

At any time in your life, **did you hit your head or was your head hit during** any of the following? This includes severe blows to the face.	**F** **# times**
Vehicle Accidents:	
1. A car wreck?	
2. A motorcycle wreck?	
3. A bicycle accident?	
4. Any other vehicle (e.g. snowmobile, boat)?	
Falls:	
5. A fall over 10 feet?	
6. A fall of 10 feet or less?	
Sports:	
7. Any sports event (e.g. boxing, football, skateboarding)?	
Assaults:	
8. **Any assault** on you (including severe discipline, fights, or **domestic violence**)?	
9. Has anyone shaken you really hard? (include airbag trauma if seriously shaken when it inflated)	
10. Any head injury during combat? (include blast injuries as well as direct hits)	
11. Have you ever been shot in the head?	
Other Instances of Head Injury:	
12. Any other event in which you received head trauma? (other penetrating or non-penetrating injuries):**specify**	
13. During any time in your life, have you ever had **any** loss of consciousness or been dazed ('seen stars', 'bells ringing")? This could have been due to sickness, seizure, or any cause other than a direct head injury ***if "yes" ask #15*** *(do not count in total if it refers to an injury already counted in #1 to #13)*	Y/N
14. **(*Ask only if # 13 is yes)*** When you came to, did you have any evidence of a head injury that might have resulted from falling when you lost consciousness (bumps, bruises or cuts on your head)?	

Section II - Injury Detail

- *For **INCIDENT TYPE** use question numbers from Section I **and** provide a brief description. Examples: In column A, enter "6" (any sports event), write "football". In column B, enter 7 (assaults) and write "fight".*
- *If the injury was part of an **ongoing pattern of injuries** (e.g. domestic abuse, discipline, sports injuries) record the 3 or 4, which were most severe, such as those requiring medical treatment.*
- *If the injury needs more explanation please describe it on the back of the page. Be sure to **label any additional information with the appropriate incident number and type.***
- *If there are more than six incidents, use a second sheet*

		A	B	C	D	E	F
	INCIDENT TYPE *(use the number associated with the specific type in Section 1 AND if there were multiple injuries of that type, give brief description to identify each)*						
1	**Circumstance** ***Code*** 1 = Vehicle 2 = Falls 3 = Sports 4 = Assaults 5 =Domestic violence 6.= Other						
2	**Type of injury** ***Code*** 1 = Blunt object (floor, baseball) 2 = Penetrating object (bullet, axe) 3 = Closed head injury (shaking)						
3	**Age at the time of the event**						
4	**Where** did the event occur ***Code*** 1 = Prison 2 = Community						
5	**Location** on head **Code** 1 = Face 2 = Left Side 3 = Right Side 4.= Top 5 = Back 6 = Multiple						
6	**Medical** treatment received ***Code*** 1 = Inpatient 2 = ER 3 = Outpatient 4 = None 5 = Unknown						
7	**Medical** rehabilitation or follow up care received ***Code*** 1 = Yes 2 = No 3 = Unknown						
8	Post Traumatic Amnesia (**PTA**) *(Loss of memory associated with event)* ***Code*** *1* = Yes 2 = No 3 = Unknown						
9	**Duration** of PTA ***Code*** **0 = None** 1 = 5 min or less 2 = >5 but <60 min 3 = ≥1 hour but <1 day 4 = ≥ 1 day but < 1 week 5 = ≥ 1 week **6 = Unknown**						
10	Loss of Consciousness (**LOC**) ***Code*** 1 = Yes 2 = Dazed, saw stars 3 = No 4 = Unknown						
11	**Duration** of LOC ***Code*** **0 = None** 1 = 5 min or less 2 = >5 but <60 min 3 = ≥1 hour but <1 day 4 = ≥ 1 day but < 1 week 5 = ≥ 1 week **6 = Unknown**						

Section III - Symptom Checklist

Each question has two parts to it.

- *First, does or did the client have the symptom?*
- *Second, how often did the symptom occur?*

*Code **only the most recent occurrence** of the symptom. For example, for #1, if the client does not currently have the symptom (easily distracted) but had it more than a year ago, you would enter the appropriate frequency code (0-5) under "Column C: had more than 1 year ago" and go on to question #2.*

Codes for **Frequency**:

0 Less than once a month	**2** At least once a week	**4** Several times a day
1 At least once a month	**3** At least once a day	**5** All the time

Have you ever had this symptom? *(code most recent)* **How often did you/do you have this symptom?** *(code 0-5)*	***Column A*** **Currently have**	***Column B*** **Had in Past Year**	***Column C*** **Had more than 1 year ago**	***Column D*** **Never had**
Code:	**0 1 2 3 4 5**	**0 1 2 3 4 5**	**0 1 2 3 4 5**	**6**
1. Easily distracted				
2. Trouble concentrating				
3. Trouble remembering				
4. Trouble paying attention to more than one thing				
5. Trouble in distracting environments				
6. Forgetting appointments				
7. Trouble doing more than one thing at a time				
8. Headaches				
9. Difficulty finding the right words				
10. Losing things				
11. Does work seem harder				
12. Dizziness				
13. Trouble following directions				
14. Dropping things				
15. Difficulty keeping track of things				