

**NEUROREHABILITATION SURVEY
SPAULDING REHABILITATION HOSPITAL
SPEECH LANGUAGE PATHOLOGY**

IDENTIFYING INFORMATION:

Date: _____

Phone #: (H) _____

Name: _____

(W) _____

Address: _____

Date of Birth: _____

Age: _____

Please answer the following questions about your injury:

1. Date of injury/illness: _____

2. Did you lose consciousness? Yes _____ No _____

Approximate length of time unconscious: _____

3. Do you remember the accident and/or events immediately around the injury/illness?

Yes _____ No _____ Comments: _____

4. Were you hospitalized?

Yes _____ No _____ Comments: _____

5. CT or MRI results (if applicable): Comments: _____

6. Cause of injury: (✓ all that apply)

Motor vehicle accident _____ Bike accident _____ Pedestrian _____ Sports _____

Assault _____ Work related _____ Hit by falling object _____ Fall _____

Stroke _____ Aneurysm _____ Other _____

7. Has legal action been taken in relation to this injury? Yes _____ No _____ Comments: _____

8. Prior to this injury, have you ever had a concussion or other neurological event? Yes _____ No _____

Comments: _____

BACKGROUND INFORMATION

Living Status:

1. Who lives in your household? _____

2. Has your living situation changed since your injury? _____

3. What is the highest level of education you have completed? _____

4. Have you ever been diagnosed with a learning disability? Yes _____ No _____

Comments: _____

5. Most recent employer: _____

Job responsibilities: _____

6. Has your ability to work changed since your injury? Yes _____ No _____

Comments: _____

7. What other activities were you involved in prior to your injury? (i.e. hobbies, sports, volunteering, etc.)

9. Has your ability to participate in these activities changed since your accident? Yes _____ No _____

Comments: _____

10. Have you ever been treated for depression? Yes _____ No _____

Comments: _____

11. Please list medications you are currently taking:

SYMPTOM RATING SCALE:

Please rate the severity of the following symptoms on a scale of 1-5 with 5 indicating the most severe (circle one):

						<u>Comments</u>
1. Fatigue	1	2	3	4	5	
2. Trouble concentrating	1	2	3	4	5	
3. Anxiety	1	2	3	4	5	
4. Dizziness	1	2	3	4	5	
5. Nausea	1	2	3	4	5	
6. Slower thinking	1	2	3	4	5	
7. Problems with memory and learning	1	2	3	4	5	
8. Moodiness	1	2	3	4	5	
9. Depression	1	2	3	4	5	
10. Sleep disturbances	1	2	3	4	5	
11. Difficulty putting ideas into words	1	2	3	4	5	
12. Easily overwhelmed	1	2	3	4	5	
13. Visual changes (blurring/double vision)	1	2	3	4	5	
14. Hearing problems/ringing in ears	1	2	3	4	5	
15. Sensitivity to lights or sounds	1	2	3	4	5	
16. Difficulty processing information	1	2	3	4	5	
17. Trouble with organization and time management	1	2	3	4	5	
18. Apathy	1	2	3	4	5	

SYMPTOM RATING SCALE (continued):

Please rate the severity of the following symptoms on a scale of 1-5 with 5 indicating the most severe (circle one):

						<u>Comments</u>
19. Trouble getting along with people	1	2	3	4	5	
20. Pain	1	2	3	4	5	
21. Balance/coordination problems	1	2	3	4	5	
22. Trouble learning new things	1	2	3	4	5	
23. Reading problems	1	2	3	4	5	
24. Difficulty with math and calculators	1	2	3	4	5	
25. Avoiding social situations or crowds	1	2	3	4	5	
26. Decreased judgement	1	2	3	4	5	
27. Trouble initiating/planning activities	1	2	3	4	5	
28. Personality changes	1	2	3	4	5	
29. Disinhibition	1	2	3	4	5	
30. Mental Fatigue	1	2	3	4	5	
31. Loss of taste/smell	1	2	3	4	5	
32. Headaches	1	2	3	4	5	
33. Irritability	1	2	3	4	5	
34. Anger	1	2	3	4	5	
35. Talkativeness	1	2	3	4	5	
36. Physical weakness	1	2	3	4	5	

ACTIVITY RATING SCALE:

Please indicate (by \checkmark) if you have difficulty with the following activities:

Home:

Comments

1. Preparing meals

2. Housecleaning

3. Managing finances

4. Listening to radio or

watching TV

5. Following conversations

6. Talking on the phone

7. Laundry

8. Gardening/Yard work

9. Parenting/Caring for
family members

10. Self Care

11. Entertaining

12. Other:

Community:

1. Driving

2. Following directions/using
a map

3. Attending
activities/functions
with children

4. Eating in restaurants

5. Socializing in groups

6. Grocery shopping

7. Errands

8. Using ATM/Banking

9. Keeping appointments

10. Automobile repairs and
maintenance

11. Using public transportation

12. Other:

ACTIVITY RATING SCALE (continued):

Please indicate (by √) if you have difficulty with the following activities:

Work:

1. Following a schedule _____
2. Initiating tasks _____
3. Reading complex material _____
4. Remembering what needs to be done _____
5. Completing work in a timely manner _____
6. Working in presence of distractions _____
7. Socializing in groups _____
8. Making or keeping appointments _____
9. Getting along with co-workers _____
10. Maintaining stamina _____
11. Composing written documents _____
12. Other: _____

What are your goals, reasons or hopes for beginning speech-language and cognitive therapy at this time?

Comments: _____

Sullivan, Julie and Sanders, R. Richard. (2000)

Adapted from the following references: American Congress of Rehabilitation Medicine, (1993). Definition of mild traumatic brain injury. Journal of Head Injury Rehabilitation. 8 (3) 86-87. Gillis, R. Traumatic Brain Injury Rehabilitation. Boston: Butterworth-Heinemann, 1996. Kay, T. (1996) Minor Head Injury: An Introduction for Professionals. National Head Injury Foundation.: 1-12. Spaulding Rehabilitation Hospital Speech Language Pathology Department: Mild TBI Survey (1993). Woo, E. (1990) Minor Head Injury: Minor or Misnomer. Boston: Spaulding Rehabilitation Hospital: 1-4.