

TBI CLINIC

7 One of your doctors has referred you for this evaluation because you are suspected of
' having sustained a traumatic brain injury (TBI) during a deployment to a war zone. Today's evaluation will assess a number of problem areas that may be linked to histories of brain injuries, and, based on our findings, you may be given referrals to other medical providers within this Medical Center who participate in our TBI and Related Disorders (TBIRD) program. Your appointment today will last from 3-4 hours and the results will be discussed with you before you leave. We will evaluate a number of aspects of your ability to think, remember, and process information, and will also screen for neurological and mental health problems. Please complete this questionnaire and then you will be seen by _____ for an interview and a complete explanation of today's appointment.

Name: _____

Social Security Number: _____ Date: _____

Age: _____ Date of birth: _____

Gender (circle one): Male Female

Handedness (circle one): Right Left Ambidextrous

Ethnic background (circle one): Caucasian African American Hispanic
American Indian Asian Other: _____

Marital Status (circle one): Married (first marriage) Remarried Separated
Single, never married Single, previously married Widowed

Number of children: Living with you: _____ Not living with you: _____

Service Status (circle one): Active Duty Reserves National Guard Retired

Service Branch (circle one): Navy Marines Army Air Force Coast Guard
Other: _____

Rank (e.g., E-4, O-1): _____ Rating: _____

Where are you stationed (include city and state) and Unit? _____

Total years of active duty service: _____ Year entered military service (first enlistment): _____

Current Duty Status: Full Duty Limited Duty/Profile Medical Hold WTU/TPU
Other: _____

Current Job Duties (e.g. mostly admin., engine repair, air crew, etc.) _____

Years of education: _____

Academic degrees (e.g., GED, High School Diploma, A.A. degree): _____

Current and past medical problems include: _____

Current medication include: _____

List your deployments to war zones and the corresponding dates of these deployments.

Deployment location	Dates of deployment
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1) _____	_____
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2) _____	_____
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3) _____	_____
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4) _____	_____
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Yes No Since your injury, have you experienced any difficulties with coordination of motions, including during sports and leisure activities or work-related tasks?

Yes No Have you been treated and discharged from Occupational Therapy since returning from deployment?

Yes No Since returning from your recent deployment, have you needed help with activities of daily living such as cooking, bathing, dressing, laundry, eating, etc.?

Yes No Since returning, have you experienced weakness in your hands or have you had trouble using everyday objects (e.g., buttons/zippers, cell phone, key board)?

Yes No Since your injury, do you have trouble organizing work and completing it in the time allowed?

Yes No Do you feel you have hobbies you enjoy and that reduce your stress level?

Yes No Have you developed marital problems or conflict with significant others since returning from deployment(s)?

Yes No Are you experiencing a problem with chronic pain since returning from your deployment(s).

Yes No I received some sort of mental health treatment prior to any of my deployments to a war zone.

- Yes No I began receiving mental health services during a deployment to a war zone
- Yes No I have either never received mental health services or the first time I received them was after a deployment to a war zone.
- Yes No I am currently being followed by a mental health provider.

If yes, I receive mental health services at: _____

My mental health diagnoses are: _____

I am satisfied with the mental health services I am receiving: Yes No

- Yes No During my deployment, I was evaluated for a brain injury.
If yes, date(s) _____

- Yes No Since returning from deployment, I have been evaluated for a brain injury.
If yes, date(s) _____

- Yes No I have received a CT or MRI (i.e., brain scan) during or since my deployment.
If yes, date(s) _____

BERGEN INSOMNIA SCALE

Please circle the number (days of the week) below that suits you best.

During the past month, how many days a week has it taken you more than 30 minutes to fall asleep after the light was switched off?	0 1 2 3 4 5 6 7
During the past month, how many days a week have you been awake for more than 30 minutes between periods of sleep?	0 1 2 3 4 5 6 7
During the past month, how many days a week have you have you been awakened more than 30 minutes earlier than you wished without managing to fall asleep again?	0 1 2 3 4 5 6 7
During the past month, how many days a week have you felt that you have not had enough rest after waking up?	0 1 2 3 4 5 6 7
During the past month, how many days a week have you been so sleepy/tired that it has affected you at work or in your private life?	0 1 2 3 4 5 6 7
During the past month, how many days a week have you been dissatisfied with your sleep?	0 1 2 3 4 5 6 7

Did you have any injury(ies) during your deployment from any of the following? (check all that apply):

A. _____ Fragment

B. _____ Bullet

C. _____ Vehicular (any type of vehicle, including airplanes)

- D. ____ Fall
- E. ____ Blast (Improvised Explosive Device, RPG, Land Mine, Grenade, etc.)
- F. ____ Other specify: _____

Did any injury you received while you were deployed result in any of the following? (check all that apply):

- A. ____ Being dazed, confused or "seeing stars"
- B. ____ Not remembering the injury
- C. ____ Losing consciousness (knocked out) for less than a minute
- D. ____ Losing consciousness for 1-20 minutes
- E. ____ Losing consciousness for more longer than 20 minutes
- F. ____ Having any symptoms of concussion afterward (such as headaches, dizziness, irritability, etc.)
- G. ____ Head injury
- H. ____ None of the above

Are you currently experiencing any of the following problems that you think might be related to a possible head injury or concussion? (check all that apply):

- | | | | |
|---------|------------------|---------|----------------------|
| A. ____ | Headaches | E. ____ | ringing in the ears |
| B. ____ | Dizziness | F. ____ | Irritability |
| C. ____ | Memory problems | G. ____ | Sleep problems |
| D. ____ | Balance problems | H. ____ | Other specify: _____ |

The following questions address your use of alcohol over the past year. Check the appropriate answer for each item.

1. How often do you have a drink containing alcohol?

- ____ Never
- ____ Monthly or less
- ____ Two to four times a month
- ____ Two to three times a week
- ____ Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

___ 1 or 2

___ 3 or 4

___ 5 or 6

___ 7 - 9

___ 10 or more

3. How often do you have six or more drinks on one occasion?

___ Never

___ Less than monthly

___ Monthly

___ Weekly

___ Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

___ Never

___ Less than monthly

___ Monthly

___ Weekly

___ Daily or almost daily

5. How often during the past year have you failed to do what was normally expected from you because of drinking?

___ Never

___ Less than monthly

___ Monthly

___ Weekly

___ Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- No
- Yes, but not in the last year
- Yes, during the last year

10. How often has a friend, relative, doctor, or other health worker been concerned about your drinking or suggested you cut down?

- Never
- Less than monthly
- About once a month
- About once a week
- Several times a week

Have you used any illegal substances since returning from your deployment? Yes or No

If yes, please explain: _____

Disclosure Statement

The Department of Defense (DOD) has been mandated by Congress to evaluate service members who may have sustained brain injuries during deployments to combat zones. DOD has chosen to adopt the ANAM-4 TBI computerized test battery to assist in their TBI surveillance efforts. This test measures mental abilities like complex reaction time, attention and memory, which may be affected by a brain injury. This test has not been fully developed for clinical use and its accuracy and reliability in assessing brain injuries is not currently known. It is included as part of your evaluation today because the results may have value to both DOD and to you in the future.

I have read and understand the above statement.

Your Signature

Date

Contact Information

Home phone number: _____

Cell Phone: _____

Work/duty phone number: _____

What telephone number is the best one to reach you? _____

At what time? _____

Personal email address: _____

Work email address: _____

May we contact you by email? (circle one) Yes No

Please note, that personal information is always sent via encrypted email, which you may not be able to open at home. General information about your appointment may be sent in unencrypted email, which you should be able to open from any computer.

Home address: _____

