

CONCUSSION QUESTIONNAIRE

Name: _____ **Date:** _____

Please check any of the following boxes that correspond to any symptom(s) or other problems that you have had or observed recently since your injury.

Yes	Symptom Description
<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Loss of coordination
<input type="checkbox"/>	Reduced drive/motivation
<input type="checkbox"/>	Poor memory
<input type="checkbox"/>	Difficulty finishing tasks
<input type="checkbox"/>	Sleep disorders
<input type="checkbox"/>	Abnormal levels of anxiety
<input type="checkbox"/>	Reduced tolerance to alcohol
<input type="checkbox"/>	More assertiveness
<input type="checkbox"/>	Forgetful
<input type="checkbox"/>	Anger outbursts
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Absence of ability to anticipate
<input type="checkbox"/>	Inflexibility
<input type="checkbox"/>	Impaired sexual function
<input type="checkbox"/>	Language difficulty
<input type="checkbox"/>	Impaired judgment
<input type="checkbox"/>	Need day timer to remember home and/or work activities
<input type="checkbox"/>	Blurry vision
<input type="checkbox"/>	Loss of balance
<input type="checkbox"/>	Difficulty handling multiple tasks
<input type="checkbox"/>	Dizziness/lightheadedness
<input type="checkbox"/>	Irritability
<input type="checkbox"/>	Personality change
<input type="checkbox"/>	Hand tremors
<input type="checkbox"/>	ringing in ears
<input type="checkbox"/>	Less diplomatic than normal
<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	Reduced attention span
<input type="checkbox"/>	Blackouts
<input type="checkbox"/>	Indifference to other people
<input type="checkbox"/>	More shallow relationships
<input type="checkbox"/>	Difficulty with problem solving
<input type="checkbox"/>	Less mental stamina
<input type="checkbox"/>	Performance inconsistencies
<input type="checkbox"/>	Verbal learning problems
<input type="checkbox"/>	Slower reaction times

REVISED OSWESTRY DISABILITY

Name _____ Date ____/____/____ File # _____

(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 - Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- I can sit in any chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.
- I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing, because it increases the pain immediately.

SECTION 7 - Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than 1/4.
- Because of pain, my normal night's sleep is reduced by less than 1/2.
- Because of pain, my normal nights sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

SECTION 9 - Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow.
- My pain is neither getting better nor getting worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

ROLAND MORRIS DISABILITY INDEX

Name _____ Date ____/____/____ File# _____
(Please Print)

When your back hurts, you may find it difficult to do some of the things you normally do. Check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.

- I stay home most of the time because of my back.
- I change positions frequently to try and get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back , I am not doing any of the jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more.
- Because of my back , I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back.
- I have trouble putting on my socks (stockings) because of my back.
- I only walk short distances because of my back pain.
- I sleep less well because of my back pain.
- Because of my back pain, I get dressed with help from someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of my back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.