My brain injury was: ____ years ago

My age is: ____ years

today's date: _____

□ I have had <u>a medical diagnosis of brain injury</u> (check box if true) Cause of injury:

□ I sustained a brain injury without medical diagnosis (check box if true)

□ <u>I have NOT</u> ever sustained a brain injury (check box if true)

Please check the most appropriate box, or circle the item number that best matches.

	Circle a number below:				
Please rate each behavior. How often does each behavior occur? (circle a number)	Never	Seldom	Occasionally	Frequently	Always
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Eye discomfort / sore eyes / eyestrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue / very tired after using eyes all day	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
Normal indoor lighting is uncomfortable – too much glare	0	1	2	3	4
Indoors fluorescent lighting is bothersome or annoying	0	1	2	3	4
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight aheadisn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4
Short attention span / easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension / can't remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place / have to use finger not to lose place when reading	0	1	2	3	4