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## TBIQS- BRIEF SCREENING TOOL TO IDENTIFY WARRIOR BRAIN INJURIES

1). While on active duty, did you experience any of the potential sources of head trauma listed below? Please check all that apply and designate the date(s) of occurrence(s), if possible:

4	_ Motor vehicle accident	Date:	
В	_ Airplane or helicopter crash	Date:	
C	_ Improvised explosive or other blast (i.e. RPG, grenade)	Date:	
D	_ Bullet wound to head	Date:	
E	_ Struck head in fall	Date:	
F	Punched or struck in head	Date:	
G	Athletic injury (for example, having your "bell rung" in football)	Date:	

2). For each item you endorsed, please answer the following questions in accordance with the letter items you selected by circling yes or no and elaborating when appropriate:

	A	В	C	D	E	F	G
I Did you sustain any physical injuries to your face or head? If yes, briefly describe:	Yes / No						
II Did you lose consciousness? If yes, briefly specify the duration using minutes, hours or days to describe it:	Yes / No						
III Did you have any amnesia for the time just prior to the trauma? If yes, indicate approximately how much time you lost using minutes, hours or days to describe:	Yes / No						
IV Did you have any amnesia for the time immediately after the trauma? If yes, indicate approximately how long this lasted using minutes, hours or days to describe:	Yes / No						

## 3). Please answer the following questions about the injury/injuries described by circling yes or no and elaborating when appropriate:

	A	В	C	D	E	F	G
I Did the injury cause any short-term or long-term disablement?	Yes / No						
II Did you receive or require acute medical attention from a medic or another provider? If yes, indicate from whom and where you received this care:	Yes / No						
III Were you hospitalized for this injury? If yes, where and for how long?	Yes / No						
IV Did you receive long-term treatment or rehabilitation?	Yes / No						
V Did you develop any symptoms such as headaches, dizziness, issues with concentration or memory, irritability, or a short fuse after this trauma? If yes, list the major symptoms you had and how long each symptom lasted (or if you still have them):	Yes / No						

Н	Childhood physical abuse	Date:
I	Substance abuse (alcohol, street drugs, or prescriptions)	Date:
J	Motor vehicle accident with head trauma	Date:
K	Fights resulting in head trauma	Date:
L	Other accidents resulting in head trauma	Date:
M	Athletic injury (for example, having your "bell rung" in foot	ball) Date:

4). Please check all that apply in regards to you your pre-service history, and designate the date(s) of occurrence(s), if possible:

5.) For each item you endorsed, please answer the following questions in accordance with the letter items you selected by circling yes or no and elaborating when appropriate:

	Н	I	J	K	L	M	N
I Did you lose consciousness? If yes, briefly specify the duration using minutes, hours or days to describe it:	Yes / No						
II Did the injury cause any short-term or long-term	Yes / No						
disablement?  III Did you receive or require acute medical attention from a medic or another provider? If yes, indicate from whom and where you received it:	Yes / No						
IV Were you hospitalized for this injury? If yes, where and for how long?	Yes / No						
V Did you develop any symptoms such as headaches, dizziness, issues with concentration or memory, irritability, or a short fuse after this trauma? If yes, list the major symptoms you had and how long each symptom lasted (or if you still have them):	Yes / No						