

## Brain Injury Quality of Life Survey

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Person Filling out this survey: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Place a check in the box that corresponds to the frequency of each symptom you have.

Symptoms	Never	Seldom (1-2x/mo)	Occasionally (3-5x/mo)	Frequently (2-3x/wk)	Always (4-5x/wk)
Blur when looking at near	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches with near work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Words run together when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning, itchy, watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falling asleep when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision is worse at the end of the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skipping/repeating lines when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head tilt/closing 1 eye when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty focusing/changing focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoiding near work/reading/writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Omitting small words when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing up/down hill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty aligning columns of numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inconsistent performance in work or sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hold reading material too close	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble keeping attention on reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult to stay on task	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty trying new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoiding physical activity that requires coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor eye/hand or fine motor coordination (i.e. handwriting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do not judge distances accurately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clumsy, knock things over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor time management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do not count or make change well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lose belongings/things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Car/motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetful/poor memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Office Use Only</b>	<b>Total</b>	_____	_____	_____	_____

**DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:**

	<u>Yes</u>	<u>No</u>	<u>Prior to injury?</u>	<u>Describe</u>
Eyes ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes pull or tug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty moving or turning eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with movement of eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes twitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain in or around eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eye redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brightness is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blurred vision at distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
One eye turns in, out, up or down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Movement of objects in the environment is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluorescent light is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patterned wallpaper or carpets are bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Head moves when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lose place often when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discomfort when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of interest/concentration when doing close work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Orient writing/drawing poorly on page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Postural changes when doing deskwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with peripheral vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Objects jump in and out of field of view	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reduced depth perception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tunnel vision / Loss of visual field	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Flashes of light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with bathing / personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty following a series of directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty using both sides of the body together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dislike heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Awkward, poor balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Confusion / disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Get lost often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bothered by noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bothered by touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty remembering things heard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty remembering things seen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty remembering name of objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty remembering people's names	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty recalling information known in the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty remembering formerly familiar people / objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty performing tasks that were formerly easy / routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	