

FUNCTIONAL SYMPTOM QUESTIONNAIRE

The following questionnaire was designed to evaluate many areas of cognitive functioning based on the perceptions of the individual. It is used to measure progress over time. It is a valid and reliable tool used to discriminate between mild to moderate TBI and non-injured individuals. It is suggested that you retake this Symptom Questionnaire every three to six months to measure your progress.

Name: _____ Date: _____

Please read this list (or it will be read to you) and indicate any problems that you may be having. Rate your problems on this scale: Almost Never, Occasionally, Sometimes, Frequently, Almost Always.

Memory

		Almost Never	Occasionally	Sometimes	Frequently	Almost Always
1.	Are you losing or misplacing items?					
2.	Are you forgetting what people tell you?					
3.	Do you forget where you parked your car?					
4.	Are you forgetting what you've read?					
5.	Are you having difficulty remembering things from the past?					

Attention and Concentration

		Almost Never	Occasionally	Sometimes	Frequently	Almost Always
1.	Are you having trouble concentrating?					
2.	Do you have difficulty concentrating in noisy environments?					
3.	Do you have difficulty concentrating on more than one thing at a time?					
4.	Do you have difficulty focusing your attention while reading or watching TV?					
5.	Are you having difficulty staying focused when you are driving?					

Language and Communication

		Almost Never	Occasionally	Sometimes	Frequently	Almost Always
1.	Do you have difficulty understanding other people or following a conversation?					
2.	Do you have difficulty thinking of words?					
3.	Do you have problems expressing yourself in writing?					
4.	Do you have difficulty expressing yourself verbally (e.g., do people ask you to repeat yourself)?					
5.	Do you have difficulty spelling words?					

Balance/Coordination/Sensory Function

		Almost Never	Occasionally	Sometimes	Frequently	Almost Always
1.	Do you find you have difficulty with handwriting, hitting a ball, riding a bicycle, or doing something that used to be easy to do?					
2.	Do you have problems with balance or coordination?					
3.	Do you experience increased fatigability?					
4.	Do you experience loss or decrease in sense of taste?					
5.	Do you experience loss or decrease in sense of smell?					
6.	Do you experience physical pain?					
7.	Do you experience sleep disturbance?					

Visual-Perception

		Almost Never	Occasionally	Sometimes	Frequently	Almost Always
1.	Do you have increased sensitivity to light?					
2.	Do objects seem closer or farther away than they actually are?					
3.	When reading, do printed letters appear to change or change position? Do you see two of things when there is only one?					
4.	Do you have difficulty focusing your eyes on objects?					
5.	Do you feel dizzy or nauseous?					

Executive Function

		Almost Never	Occasionally	Sometimes	Frequently	Almost Always
1.	Do you have difficulty planning work or leisure activities?					
2.	Do you have problems setting goals and priorities?					
3.	Do you have difficulty starting new tasks?					
4.	Do you have difficulty monitoring and correcting your errors?					
5.	Do you have difficulty changing from one task to another?					

Emotional Functioning

		Almost Never	Occasionally	Sometimes	Frequently	Almost Always
1.	Have you noticed increased moodiness?					
2.	Do you lose your temper more quickly than before?					
3.	Do you feel depressed?					
4.	Do you have feelings of anxiety or nervousness?					
5.	Do family and friends comment on changes in your behavior?					
6.	Do you have increased irritability?					

Finances and Measurements

		Almost Never	Occasionally	Sometimes	Frequently	Almost Always
1.	Do you have difficulty performing simple addition and subtraction?					
2.	Do you have difficulty making change at the store?					
3.	Do you have difficulty balancing your checkbook as accurately as before?					
4.	Do you have difficulty paying your bills on time?					
5.	Do you have difficulty calculating the appropriate measurements for recipes or other projects?					

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Organization and Sequencing

		Almost Never	Occasionally	Sometimes	Frequently	Almost Always
1.	Do you have difficulty following the steps of a recipe?					
2.	Are you having difficulty attending to your mail on a regular basis?					
3.	Are you having difficulty doing or keeping up with normal routine household chores?					
4.	Do you have difficulty doing more than one thing at a time?					
5.	Do you have difficulty effectively managing your time?					

Safety

		Almost Never	Occasionally	Sometimes	Frequently	Almost Always
1.	Do you forget to turn off the iron, stove, or other electrical appliances?					
2.	Do you forget where you're going when you get into your car?					
3.	Do you forget to lock your doors at home?					
4.	Do you forget important appointments (e.g., picking up your children, etc.)?					
5.	Do you feel that your awareness levels are less than they should be?					

UNDERSTANDING YOUR RESULTS

There are 53 items on the Symptom Questionnaire for MTBI. By adding up the number of Xs in each column (Almost Never, Occasionally, Sometimes, Frequently, and Almost Always), and dividing each one by the total number of items in the questionnaire (53), you will get a percentage of how often you have symptoms at each severity level. For example, if you have 10 in the Almost Always category and divide 10 by 53, your result will be 19%. Try using this assessment tool every three to six months to track your progress and to pinpoint areas that need attention. Remember, the healing process is unique to everyone and the physical, emotional, cognitive and thinking abilities improve at different rates.