



Brain Check Survey

Available for use at: [LOBI \(http://www.lobi.chhs.colostate.edu/index.aspx\)](http://www.lobi.chhs.colostate.edu/index.aspx)

To be filled out by the parent/guardian

Student / Family Information

Today's Date: ___/___/___ Child's Name: _____ Child's Age: _____

Child's Date of Birth: ___/___/___ Child's Gender: Male Female

Please answer the following questions about **YOURSELF**:

Are you the student's (circle all that apply)?

Mother Father Foster Parent Other (ex: stepmother) please describe: _____

Your Name (printed): _____

Your Signature: _____

Contact information: Email _____

Phone _____

Injuries or Illnesses

Injury or Illness	Age	Outcomes
<i>Please check all that apply</i>		
<input type="checkbox"/> Blow to Head (From sports, playing, biking, falling, getting hit by an object, etc.)	At what age? _____	<i>Check all that apply:</i> <input type="checkbox"/> Concussion <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____ <input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school <input type="checkbox"/> Resulted in no problem
<input type="checkbox"/> Whiplash	At what age? _____	<i>Check all that apply:</i> <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____ <input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school <input type="checkbox"/> Resulted in no problem
<input type="checkbox"/> Car accident (resulting in any degree of injury or lack of injury)	At what age? _____	<i>Check all that apply:</i> <input type="checkbox"/> Concussion <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____

Injury or Illness	Age	Outcomes
		<input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school <input type="checkbox"/> Resulted in no problem
<input type="checkbox"/> Assault/Violence (child abuse, fights, firearm injury)	At what age? ____	<i>Check all that apply:</i> <input type="checkbox"/> Concussion <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____ <input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school <input type="checkbox"/> Resulted in no problem
<input type="checkbox"/> Sustained High Fever	At what age? ____	<i>Check all that apply:</i> <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____ <input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school <input type="checkbox"/> Resulted in no problem
<input type="checkbox"/> Brain Tumor	At what age? ____	<i>Check all that apply:</i> <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____ <input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school <input type="checkbox"/> Resulted in no problem
<input type="checkbox"/> Anoxia (definition: lack of oxygen; caused by such events as a near-drowning experience or suffocating experience)	At what age? ____	<i>Check all that apply:</i> <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____ <input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school <input type="checkbox"/> Resulted in no problem
<input type="checkbox"/> Meningitis	At what age? ____	<i>Check all that apply:</i> <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____ <input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school <input type="checkbox"/> Resulted in no problem
<input type="checkbox"/> Encephalitis	At what age? ____	<i>Check all that apply:</i> <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____ <input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school <input type="checkbox"/> Resulted in no problem
<input type="checkbox"/> Seizures (example: epilepsy)	At what age? ____	<i>Check all that apply:</i> <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____ <input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school

Injury or Illness	Age	Outcomes
<input type="checkbox"/> Overdose of Drugs or alcohol, or inappropriate use of prescription drugs or over- the-counter medication?	At what age? ____	<input type="checkbox"/> Resulted in no problem <i>Check all that apply:</i> <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____ <input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school <input type="checkbox"/> Resulted in no problem
<input type="checkbox"/> Other: _____ _____	At what age? ____	<i>Check all that apply:</i> <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____ <input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school <input type="checkbox"/> Resulted in no problem
<input type="checkbox"/> Other: _____ _____	At what age? ____	<i>Check all that apply:</i> <input type="checkbox"/> Loss of consciousness, *for how long? _____ <input type="checkbox"/> Coma, *for how long? _____ <input type="checkbox"/> Confusion or altered mental state <input type="checkbox"/> Missed school <input type="checkbox"/> Resulted in no problem

Has your child ever been to the emergency department? Yes No

If YES, at what age? _____ Please explain:

Behaviors that can affect learning

Please tell us about your child's learning styles and behaviors:

Learning Style or Behavior	Circle the number on the scale which best describes your child:					
	(1) No Problem \longleftrightarrow Extreme Problem (6)					
Coping with change or transitions	1	2	3	4	5	6
Maintaining family and friend relationships	1	2	3	4	5	6
Letting go of one activity to attend to another	1	2	3	4	5	6
Reaction to simple problems	1	2	3	4	5	6
Waiting for his or her turn in a game	1	2	3	4	5	6
Learns from past mistakes or behavior	1	2	3	4	5	6
Thinks before speaking or acting	1	2	3	4	5	6
Listens without interrupting others often	1	2	3	4	5	6
Handles a change in plans	1	2	3	4	5	6
Demonstrates good judgment	1	2	3	4	5	6

Cognitive Processes that can affect learning

Please tell us about your child's learning styles:

Learning Style or Cognitive Processes	Circle the number on the scale which best describes your child:					
	(1) No Problem \longleftrightarrow Extreme Problem (6)					
Focusing and maintaining attention	1	2	3	4	5	6
Getting started on activities, tasks, chores, homework and the like, on his or her own	1	2	3	4	5	6
Monitoring own progress on homework, assignments, chores, and the like	1	2	3	4	5	6
Solving everyday problems (example: thinking of different options when something is not working for him/her.)	1	2	3	4	5	6
Learns new things easily	1	2	3	4	5	6
Remembers lists	1	2	3	4	5	6
Remembers day-to-day events	1	2	3	4	5	6

Symptoms – Part 1 (Sensory)

If your child has experienced any of the following symptoms, rank the severity of those symptoms:

Sensory Symptom	Circle the number on the scale which best describes your child:					
	(1) No Problem \longleftrightarrow Extreme Problem (6)					
Headaches and/or Migraines (sudden, not responsive to medications, can last for more than a day)	1	2	3	4	5	6
Blank staring/Day dreaming	1	2	3	4	5	6
Dizziness	1	2	3	4	5	6
Change in vision (blurred vision, double vision, depth perception)	1	2	3	4	5	6
Fatigue (tires easily, is often tired)	1	2	3	4	5	6
Light sensitivity (can be easily upset by bright or strobe lights)	1	2	3	4	5	6

Symptoms – Part 2 (Motor)

If your child has experienced any of the following symptoms, rank the severity of those symptoms:

Motor Symptom	Circle the number on the scale which best describes your child:					
	(1) No Problem \longleftrightarrow Extreme Problem (6)					
Loss of muscle coordination (can look like awkward movements, problems with balance, slowed reactions, uncoordinated running and catching)	1	2	3	4	5	6
Blackouts/ Fainting	1	2	3	4	5	6
Confusion	1	2	3	4	5	6
Seizures	1	2	3	4	5	6
Slurred speech	1	2	3	4	5	6
Has trouble finding the “right” word when talking	1	2	3	4	5	6

Educational Service

Is your child having difficulties with school performance? Please describe:

What does your child do best at in school? Please describe:

Is your child currently receiving any of the following services?

Check all that apply (If “yes”, please check if they are provided through school and/or being provided privately.)

Check all that apply
(If “yes”, please check if they are provided through school and/or being provided privately.)
Child’s Status (please check)

Service

Occupational therapy No Yes
If Yes, please check whether these services are delivered by:
 school-supported specialists (the school pays for the specialist); and/or
 by private specialists (you and/or your insurance pays)

Physical therapy No Yes
If Yes, please check whether these services are delivered by:
 school-supported specialists (the school pays for the specialist); and/or
 by private specialists (you and/or your insurance pays)

Speech-Language therapy No Yes
If Yes, please check whether these services are delivered by:
 school-supported specialists (the school pays for the specialist); and/or
 by private specialists (you and/or your insurance pays)

Other: _____ No Yes
If Yes, please check whether these services are delivered by:
 school-supported specialists (the school pays for the specialist); and/or
 by private specialists (you and/or your insurance pays)

Has your child ever been evaluated for special education services? YES NO
If Yes, at what age was your child first evaluated? _____

Does your child have a 504 plan? YES NO
If Yes, are the accommodations helping your child’s school performance? YES NO

Does your child have an IEP, Individualized Education Plan?
 No
 Yes → if YES, please answer 1 & 2 immediately below:
1. Is the IEP helping your child’s school performance? YES NO
2. Please check all categories listed on the IEP:
 Hearing Impairment, Including deafness
 Multiple Disabilities
 Deaf-Blindness
 Autism Spectrum Disorder
 Orthopedic Impairment

- Other Health Impaired
- Traumatic Brain Injury (TBI)
- Developmental Delay
- Serious Emotional Disability
- Intellectual Disability
- Specific Learning Disability
- Speech or Language Impairment
- Visual Impairment, Including Blindness