CASE ID: _____ Date: _____ Screener Last Name, First Initial_____

Mental Health/TBI Screening Project

Directions: Please circle appropriate answer and fax or email to April Turner

April.Turner@rehab.alabama.gov | FAX: 205-945-8517 ***ATTN: April Turner*** | Phone: 334-293-7116

Demographics

Agency (circle one)

Bryce
East Alabama Mental Health Center Outpatient Clinic
East Alabama Mental Health Center Chemical Addictions Program
Aletheia House Muscle Shoals
Mission of Mercy Shoals (MOMS) Florence
Other

Race (circle one)

American Indian/Alaska Native
Asian
Native Hawaiian or Other Pacific Islander
Black or African American
White
Hispanic
More than One Race
Unknown/Not Reported

Gender (circle one)

Male
Female
Other

Are you currently insured? (circle one)

Yes
No

What is your current relationship status? (circle one)

Single/Never Married
Married
Partnered
Widowed
Divorced

What is your current age?

_____ years

Years of education

_____ years

Are you currently employed? (circle one)

Yes
No

Have you ever served in the military? (circle one)

Yes, Active
Yes, Veteran
No

If you have served in the military, which branch? (circle one)

Army
Navy
Air Force
Marines
National Guard
Other Uniformed Service

Health

Please indicate if you have been diagnosed with any of the following physical health conditions. Check all that apply.

- ☐ Arthritis
- ☐ Blood Pressure
- ☐ Cancer
- ☐ Cholesterol
- ☐ Chronic Pain
- ☐ Dementia
- ☐ Diabetes
- ☐ Digestion/GI Problems
- ☐ Sensory Deficits
- ☐ Heart
- ☐ HIV/AIDS/Infectious Disease
- ☐ Lung Conditions
- ☐ Migraine/Headaches
- ☐ Neurology
- ☐ Skin
- ☐ Thyroid
- ☐ Other _____

This project was supported, in part by grant number 90TBSG0044-01-00, from the US Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.

CASE ID: _____ Date: _____ Screener Last Name, First Initial_____

Please indicate if you have been diagnosed with any of the following mental health conditions. Check all that apply.

- ☐ Anxiety Disorder
- ☐ Childhood Mental Disorder
- ☐ Cognitive Disorder
- ☐ Dissociative Disorder
- ☐ Eating Disorder
- ☐ Impulse Control Disorder
- ☐ Mood Disorder
- ☐ Organic Brain Disorder
- ☐ Personality Disorder
- ☐ Psychotic Disorder
- ☐ Sexual Disorder
- ☐ Sleep Disorder
- ☐ Trauma/Stress Disorder
- ☐ Other _____

Please indicate if you are taking any of the following medications. Check all that apply.

- ☐ Combination Antipsychotic and Antidepressant Medication
- ☐ Antipsychotic Medication
- ☐ Antidepressant Medication
- ☐ Mood Stabilizing and Anticonvulsant Medication
- ☐ Anti-anxiety Medication
- ☐ ADHD Medication
- ☐ Medical for Secondary Health Conditions

Do you take your medications as prescribed? (circle one)

Yes

No

Please indicate if you have abused any of the following. Check all that apply.

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ K2/Spice
- ☐ Prescription Drugs
- ☐ OTC Drugs
- ☐ Amphetamines
- ☐ Steroids
- ☐ Bath Salts
- ☐ Cocaine
- ☐ Hallucinogens
- ☐ Heroin
- ☐ Inhalants
- ☐ Ketamine/GHB/Rohypnol
- ☐ Other _____

How old were you when you first used one of these substances?

_____ years

Are you a childhood victim of violence? (circle one)

Yes

No

Are you an adult victim of violence? (circle one)

Yes

No

Have you ever attempted suicide? (circle one)

Yes

No

How many times have you ever attempted suicide?

_____ number of times

How old were you when you first attempted suicide?

_____ years

Complete and return to April.Turner@rehab.alabama.gov | FAX: 205-945-8517 ***ATTN: April Turner*** *| Phone: 334-293-7116*

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Ohio State University TBI Identification Method — Interview Form

Step 1

Ask questions 1-5 below. Record the cause of each reported injury and any details provided spontaneously in the chart at the bottom of this page. You do not need to ask further about loss of consciousness or other injury details during this step.

I am going to ask you about injuries to your head or neck that you may have had anytime in your life.

1. In your lifetime, have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about.
   ☐ No ☐ Yes—Record cause in chart
2. In your lifetime, have you ever injured your head or neck in a car accident or from crashing some other moving vehicle like a bicycle, motorcycle or ATV?
   ☐ No ☐ Yes—Record cause in chart
3. In your lifetime, have you ever injured your head or neck in a fall or from being hit by something (for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock)? Have you ever injured your head or neck playing sports or on the playground?
   ☐ No ☐ Yes—Record cause in chart
4. In your lifetime, have you ever injured your head or neck in a fight, from being hit by someone, or from being shaken violently? Have you ever been shot in the head?
   ☐ No ☐ Yes—Record cause in chart
5. In your lifetime, have you ever been nearby when an explosion or a blast occurred? If you served in the military, think about any combat- or training-related incidents.
   ☐ No ☐ Yes—Record cause in chart

Interviewer instruction:
If the answers to any of the above questions are "yes," go to Step 2. If the answers to all of the above questions are "no," then proceed to Step 3.

Step 2

Interviewer instruction: If the answer is "yes" to any of the questions in Step 1 ask the following additional questions about each reported injury and add details to the chart below.

Were you knocked out or did you lose consciousness (LOC)?

If yes, how long?

If no, were you dazed or did you have a gap in your memory from the injury?

How old were you?

Step 3

Interviewer instruction: Ask the following questions to help identify a history that may include multiple mild TBIs and complete the chart below.

Have you ever had a period of time in which you experienced multiple, repeated impacts to your head (e.g. history of abuse, contact sports, military duty)?

If yes, what was the typical or usual effect––were you knocked out (Loss of Consciousness - LOC)?

If no, were you dazed or did you have a gap in your memory from the injury?

What was the most severe effect from one of the times you had an impact to the head?

How old were you when these repeated injuries began? Ended?

Step 1	Step 2						
	Loss of consciousness (LOC)/knocked out				Dazed/Mem Gap		Age
Cause	No LOC	< 30 min	30 min-24 hrs	> 24 hrs	Yes	No	

If more injuries with LOC: How many?_____ Longest knocked out?_____ How many ≥ 30 mins.?_____ Youngest age? _____

Step 3	Typical Effect		Most Severe Effect				Age	
Cause of repeated injury	Dazed/ memory gap, no LOC	LOC	Dazed/ memory gap, no LOC	LOC < 30 min	LOC 30 min - 24 hrs.	LOC > 24 hrs.	Began	Ended

Adapted with permission from the Ohio State University TBI Identification Method (Corrigan, J.D., Bogner, J.A. (2007). Initial reliability and validity of the OSU TBI Identification Method. J Head Trauma Rehabil, 22(6):318-329.

(Continuation from reverse side, if needed)

CASE ID: _____ *Date:* _____ *Screener Last Name, First Initial*_____

Step 1	Step 2						
	Loss of consciousness (LOC)/knocked out				Dazed/Mem Gap		Age
Cause	No LOC	< 30 min	30 min-24 hrs	> 24 hrs	Yes	No	

If more injuries with LOC: How many?_____ Longest knocked out?_____ How many ≥ 30 mins.?_____ Youngest age? _____

Step 3	Typical Effect		Most Severe Effect				Age	
Cause of repeated injury	Dazed/ memory gap, no LOC	LOC	Dazed/ memory gap, no LOC	LOC < 30 min	LOC 30 min - 24 hrs.	LOC > 24 hrs.	Began	Ended

Interpreting Findings

A person may be more likely to have ongoing problems if they have any of the following:

- **WORST**
  One moderate or severe TBI
- **FIRST**
  TBI with loss of consciousness before age 15
- **MULTIPLE**
  2 or more TBIs close together, including a period of time when they experienced multiple blows to the head
- **RECENT**
  A mild TBI in the last weeks or a more severe TBI in the last months
- **OTHER SOURCES**
  Any TBI combined with another way that their brain function has been impaired

For more information about TBI or the OSU TBI Identification Method visit:

- Ohio Valley Center at OSU
  www.ohiovalley.org/informationeducation
- BrainLine.org
  www.brainline.org

(Updated July 2013)