BRAIN INJURY ASSOCIATION OF VIRGINIA

2810 N. Parham Road | Suite 260 | Richmond, VA 23294
Phone: (804) 355-5748 | Toll Free: (800) 444-6443
www.biav.net

THE VOICE OF BRAIN INJURY

Brain Injury Association of Virginia			
Traumatic Brain Injury (TBI) Guided Credible History Interview Template			
(Adapted from Oregon Dept. of Education)			
Date of Interview: Click or tap here to enter text.		Individual Conducting Interview: Click or tap here to enter text.	
IDENTIFYING INFORMATION			
Name of Individual: Click or tap here to enter text.			
Birthdate: Click or tap to enter a date.	Age: Click or tap here to enter text.	Sex: Click or tap here to enter text.	Employment: Grade: Click or tap here to enter text.
Person Interviewed: Click or tap here to enter text.		Relationship to Individual: Click or tap here to enter text.	
DEVELOPMENTAL HISTORY			
Were there any complications during the pregnancy or birth?		Yes ☐	No ☐
Explain: Click or tap here to enter text.			
Was there any use of alcohol, cigarettes, or drugs during pregnancy?		Yes ☐	No ☐
Explain: Click or tap here to enter text.			
Did s/he crawl by 9 months?		Yes ☐	No ☐
Did s/he walk by 18 months?		Yes ☐	No ☐
Did s/he speak single words by 15 months?		Yes ☐	No ☐
Did s/he use two-to-three word sentences by 24 months?		Yes ☐	No ☐
Were there problems with balance or coordination?		Yes ☐	No ☐
Were there problems with fine motor skills? (picking something up, buttons, feeding self)		Yes ☐	No ☐
Were there problems in school?			
Explain: Click or tap here to enter text.			
MEDICAL HISTORY			
Major Illnesses *(include age at onset and brief explanation):*			
Hospitalization/Surgeries *(include age at onset and brief explanation):*			
Accidents/Injuries *(include age at onset and brief explanation):*			
Does s/he have any known hearing problems?		Yes ☐	No ☐
If yes, when did problem start? Explain: Click or tap here to enter text.			
Does s/he have any known vision problems?		Yes ☐	No ☐
If yes, when did problem start? Please note if glasses have been prescribed and if they are worn. Explain: Click or tap here to enter text.			
Does s/he have any physical disabilities?		Yes ☐	No ☐
If yes, when did problem start? Explain: Click or tap here to enter text.			
Has s/he ever had seizures?		Yes ☐	No ☐
Date of last seizure:			
Explain: Click or tap here to enter text.			
Does s/he have frequent headaches?		Yes ☐	No ☐

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Has s/he ever had a head injury or concussion?	Yes ☐	No ☐
After injury, did s/he experience *(please include date of onset of symptoms):*	Dizziness? ☐	Memory Problems? ☐
	Headaches? ☐	Fatigue? ☐
Was a physician seen for the injury?	Yes ☐	No ☐
	Who:	
Was s/he hospitalized?	Yes ☐	No ☐
	Where?	
Does s/he have sleeping issues?	Yes ☐	No ☐
If yes, when did problem start? Explain: Click or tap here to enter text.		
Does s/he have behavior problems?	Yes ☐	No ☐
If yes, when did problem start? Explain: Click or tap here to enter text.		
Has s/he been diagnosed with any mental health conditions?	Yes ☐	No ☐
If yes, when did problem start? Explain: Click or tap here to enter text.		
MEDICATIONS		
Is s/he currently taking medications (prescription and/or over-the-counter)?	Yes ☐	No ☐
List Name, Dose, and Time: Click or tap here to enter text.		
Explain: Click or tap here to enter text.		

INJURIES AND ILLNESSES THAT MAY BE RELATED TO TBI		
Please check all that apply		
Injury or Illness	**Age of Onset**	**Outcomes (check all the apply)**
☐ Car crash, with any degree of injury ☐ Blow to head (from sports, playing, biking, falling, hit by object, etc.) ☐ Assault/violence (child abuse, fights, firearm injury) ☐ Sustained high fever ☐ Brain tumor ☐ Anoxia (lack of oxygen caused by such events as a near- drowning or suffocating experience ☐ Meningitis ☐ Encephalitis ☐ Seizures (e.g. epilepsy) ☐ Overdose of drugs or alcohol or inappropriate use of prescription drugs or over-the-counter medication ☐ Other:		☐ Concussion ☐ Loss of consciousness *for how long? ☐ Coma *for how long? ☐ Confusion or altered state of mind ☐ Medical attention sought ☐ Missed work/school ☐ Resulted in no problems

Additional Information (when/where did incident occur, what type of medical intervention was sought, what symptoms occurred / what did you observe, when did s/he start to feel better, were any accommodations needed at school or work, etc): Click or tap here to enter text.

CHALLENGES AFFECTING INDEPENDENT LIVING		
Behavior	**Impact**	**Age of Onset**
Memory issues:	☐ No Concern ☐ Some Concern ☐ High Concern	
Sustained attention:	☐ No Concern ☐ Some Concern ☐ High Concern	
Initiation:	☐ No Concern ☐ Some Concern ☐ High Concern	
Task completion:	☐ No Concern ☐ Some Concern ☐ High Concern	
Being understood (speech is easy to understand, speaks clearly):	☐ No Concern ☐ Some Concern ☐ High Concern	
Planning and organization:	☐ No Concern ☐ Some Concern ☐ High Concern	
Problem-solving:	☐ No Concern ☐ Some Concern ☐ High Concern	
Able to learn new information:	☐ No Concern ☐ Some Concern ☐ High Concern	
Emotional status:	☐ No Concern ☐ Some Concern ☐ High Concern	
Substance misuse:	☐ No Concern ☐ Some Concern ☐ High Concern	
Impulse control:	☐ No Concern ☐ Some Concern ☐ High Concern	
Social turn-taking:	☐ No Concern	

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CHALLENGES AFFECTING INDEPENDENT LIVING		
	☐ Some Concern ☐ High Concern	
Judgement:	☐ No Concern ☐ Some Concern ☐ High Concern	
Perseveration:	☐ No Concern ☐ Some Concern ☐ High Concern	

SYMPTOMS		
Has s/he experienced any of the following symptoms? If so, please rank the severity of those symptoms. (1 = once weekly, 2= multiple times per week; 3 = daily		
Symptoms	**Not a problem**	**Circle the number on the scale that best describes the symptom:**
Headaches and/or migraines (sudden, not responsive to medication, can last for more than a day)		☐ 1 ☐ 2 ☐ 3
Confusion	☐ N/A	☐ 1 ☐ 2 ☐ 3
Blank staring/daydreaming	☐ N/A	☐ 1 ☐ 2 ☐ 3
Dizziness	☐ N/A	☐ 1 ☐ 2 ☐ 3
Sleepiness (has trouble staying awake during the day)	☐ N/A	☐ 1 ☐ 2 ☐ 3
Fatigue (tires easily, is often tired)	☐ N/A	☐ 1 ☐ 2 ☐ 3
Seizures	☐ N/A	☐ 1 ☐ 2 ☐ 3
Has trouble finding the “right” word when talking	☐ N/A	☐ 1 ☐ 2 ☐ 3
Noise sensitivity	☐ N/A	☐ 1 ☐ 2 ☐ 3
Light sensitivity	☐ N/A	☐ 1 ☐ 2 ☐ 3
Mood swings (unusual or quick changes among sadness, happiness, depression, anxiety, anger)	☐ N/A	☐ 1 ☐ 2 ☐ 3
Explain: Click or tap here to enter text.		

SUPPORT SERVICES	
Has s/he received any of the following services to address independent living skills:	
Occupational Therapy	☐ No ☐ Yes Comments:
Physical Therapy	☐ No ☐ Yes Comments:
Special Education	☐ No ☐ Yes Comments:
Speech-Language Therapy	☐ No ☐ Yes Comments:
Supported Employment	☐ No ☐ Yes Comments:
Behavioral Therapy	☐ No ☐ Yes Comments:
Additional Services, therapies or treatments: Click or tap here to enter text.	

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OTHER RELEVANT HISTORY
Click or tap here to enter text.

Signature of person completing this form: Click or tap here to enter text.	Date: Click or tap to enter a date.
Role/Position: Click or tap here to enter text.	