BRAIN INJURY ASSOCIATION OF VIRGINIA

# HELPS Brain Injury Screening Tool (Modified)

1. Have you ever had a hit to your head, been strangled or choked? □ Yes □No

2. If yes, how did it happen? Check all that apply.
    a. Playing sports
    b. Riding a bike
    c. From a fall
    d. From an assault or fight
    e. From a car accident
    f. From something else? If so, what?

3. When did it happen? Check all that apply.
    a. Within the past month
    b. Within the past year
    c. 1-2 years ago
    d. 3-5 years ago
    e. More than 5 years ago

4. How many times has your head or neck been hurt?
    a. 1-3
    b. 4-6
    c. More than 6
    d. Not sure

5. Were you ever seen in the emergency room, hospital, or by a doctor for a hit to your head or because of strangulation or choking? □ Yes □No

6. Were you given follow-up recommendations? □ Yes □No

7. Did you follow the recommendations? □ Yes □No

8. Did you ever black out or lose consciousness because of a hit to the head or due to choking or strangulation? □ Yes □No

9. If yes, how long were you blacked out or unconscious:
    a. Minutes
    b. Hours
    c. Days
    d. Not sure

10. Did you ever experience a period of being dazed and confused because of a hit to the head or due to choking or strangulation? □ Yes □No

11. If yes, how long did you feel dazed or confused:
    a. Minutes
    b. Hours
    c. Days
    d. Months
    e. Not sure

12. How many times have you felt this way:
    a. 1-3
    b. 4-6
    c. More than 6
    d. Not sure

13. Did you ever, or do you currently have any problems in your daily life because of a hit to your head or due to strangulation or choking? □ Yes □No

14. Did you ever or do you currently have any of the following problems following your injury? Was it in the past, are you having them now, or both?

| | | Yes | No | Now | In the past |
|---|---|---|---|---|---|
| a. Physical | | | | | |
| | Headaches | | | | |
| | Dizziness | | | | |
| | Nausea | | | | |
| | Vision problems | | | | |
| | Balance problems | | | | |
| | Fatigue | | | | |
| | Poor sleep | | | | |
| | Changes in the ability to taste or smell | | | | |
| b. Cognitive | | | | | |
| | Problems remembering things | | | | |
| | Problems focusing or concentrating | | | | |
| | Problems getting things started | | | | |
| | Problems staying organized | | | | |
| c. Emotional | | | | | |
| | Feeling confused | | | | |
| | Feeling irritable or impatient | | | | |
| | Feeling worried or nervous | | | | |
| | Feeling sad or hopeless | | | | |

Time to administer: 10-20 minutes. Should be completed in a one-on-one interview format using pen & paper.

**Scoring the HELPS Screening Tool:**

A HELPS screening is considered positive for a **possible** TBI when the following 3 items are identified:
1.) An event that could have caused a brain injury (yes to question 1 or 5), **and**
2.) A period of loss of consciousness or altered consciousness after the injury or another indication that the injury was severe (yes to questions 5, 8, or 10), **and**
3.) The presence of two or more chronic problems that were not present before the injury.