Please complete the attach Follow-Up Forms and return to the TBI Clinic upon the arrival of your appointment. If the forms are not received, we will reschedule your appointment at that time.

FOLLOW-UP FORM: WARRIOR CARE CLINIC

Your Visit Today is With: ☐ **Dr. Asobo** ☐ **Dr. Sebesta** ☐ **Ms. Chavez, NP**

PLEASE ANSWER EVERYTHING ON PAGES 1 & 2 CIRCLE or ✓CHECK WHERE APPROPRIATE

DATE:_____ **NAME:**_____ **PHONE:** (____)_____

RANK:_____ **UNIT:**_____ **DOB:**_____ **SSN:**_____

Are you in the WTB? ☐ YES ☐ NO If yes, Nurse Case Manager's name & phone:_____

Are you in a Medical Board or think you will be in one within the next 6 months? ☐ YES ☐ NO

WHERE DO YOU WANT TO PICK UP YOUR MEDS? ☐BIGGS ☐PX ☐SFMC (FT BLISS) ☐WBAMC
MEDICATION ALLERGIES? YES/NO IF YES, LIST:_____

Are you allergic to latex? Yes/No

LIST CURRENT MEDICATIONS (Circle those that need a refill.): (If none, check here☐)_____

_____

YOUR PAST MEDICAL HISTORY: (If none, check here☐) ☐ PTSD ☐ DEPRESSION ☐ ANXIETY

☐ HIGH BLOOD PRESSURE ☐ASTHMA ☐ HEADACHE. ☐Alcoholism/Alcohol Abuse ☐ Drug Abuse

☐Attention-Deficit Hyperactivity ☐Learning Disability_____ ☐Special Education_____
LIST ANY OTHERS:_____

YOUR SURGICAL HISTORY: (If none, check here☐)_____

_____

FAMILY MEDICAL HISTORY (LIST BY MOTHER/FATHER/SISTER/BROTHER). Be sure to include any mental illness, alcoholism, heart disease, cancer, or diabetes. (If none, check here☐)_____

_____

ARE YOU CURRENTLY HAVING: 1) Suicidal thoughts? ☐YES ☐NO 2) Homicidal thoughts? ☐YES ☐NO
DOMESTIC VIOLENCE IN YOUR HOME? ☐YES ☐NO ARE YOU DEPRESSED? ☐YES ☐NO

DO YOU DRINK? ☐ YES ☐ NO IF YES: How much BEER?_____ **WINE?**_____
LIQUOR?_____

TOBACCO USE? ☐ YES ☐ NO IF YES: WHAT TYPE?_____
QUANTITY:_____ **Do you want to quit? Yes / No**

LEVEL OF PAIN AT THIS MOMENT: 0 1 2 3 4 5 6 7 8 9 10 WHERE?_____

HAVE YOU HAD A HEAD INJURY/CONCUSSION SINCE YOUR LAST VISIT? ☐ YES ☐ NO IF YES: _____

_____

_____

_____

DATE:_____2012 FIRST LETTER OF LAST NAME & LAST 4 NUMBERS FROM SSN_____

HEADACHES

HISTORY

DO YOU HAVE MODERATE OR SEVERE HEADACHES? ☐ YES ☐ NO ***(If no, skip to next page.)***
DID YOUR HEADACHES START WITH A CONCUSSION OR HEAD INJURY? ☐ YES ☐ NO
ARE YOU SATISFIED WITH THE CONTROL OF YOUR HEADACHES AT THIS TIME? ☐ YES ☐ NO

DESCRIPTION (Circle or check)

WHO HAS BEEN TREATING YOU FOR THESE HEADACHES? ☐ TBI Program ☐ Neurology

☐ Primary Care Provider ☐ Other_____

DID WE CHANGE YOUR HEADACHE MEDICATIONS AT LAST VISIT? ☐Yes ☐No

The Number of Severe Headaches I have per week or month has: ☐Stayed the Same ☐Decreased ☐Increased **How many severe headaches do you have per week** _____ **or per month?**_____

The severity of my Severe Headaches has: ☐ **Stayed the Same** ☐Decreased ☐Increased

_____

Did your Headache Medication Give You Any Side Effects? ☐Yes ☐No

If "Yes," what side effects did you have?_____

_____

DATE:_____2012 FIRST LETTER OF LAST NAME & LAST 4 NUMBERS FROM SSN_____

CHECK EACH ITEM THAT APPLIES TO YOU.

Poor Concentration: ☐ YES ☐ NO

Irritable: ☐ YES ☐ NO

Tired All the Time: ☐ YES ☐ NO

Memory Problems: ☐ YES ☐ NO

Anxiety/Worry: ☐ YES ☐ NO

Trouble Thinking/Understanding: ☐ YES ☐ NO

Dizziness /Balance Issues: ☐ YES ☐ NO (ONLY WITH HEADACHES? ☐ YES ☐ NO)

Blurry Vision: ☐ YES ☐ NO ***Double Vision***: ☐ YES ☐ NO

If you get headachess, do you have blurry/double vision ONLY WITH HEADACHES? ☐ YES ☐ NO

Sensitivity to Bright Light: ☐ WITH HEADACHES ONLY ☐ EVEN WITHOUT HEADACHES

Do you have difficulty sleeping? ☐ YES ☐ NO

If so, about how many hours total of actual sleep per night?_____

Nightmares?: ☐ YES ☐ NO

Active Sleep? ☐ YES ☐ NO If yes, do you: ☐ Yell/Scream ☐ Punch/Kick ☐ Sleep Walk.

DATE:_____ 2012 FIRST LETTER OF LAST NAME & LAST 4 NUMBERS FROM SSN_____

FOR STAFF ONLY.

HT:____ WT:____BMI:_____BP____/____HR____ RR_____ TEMP_____ O2% SAT_____

RESPECT-MIL POSITIVE SCREEN: ☐ PTSD ☐ DEPRESSION

REQUIRED INFORMATION AT DISCHARGE—Give to Ms. Calderon			
Total # of Psychotropic Medications		**Total # of Medications**	

(Do not include sleep medications in # of Psychotropic Medications)

	SM is PCSing or ETSing		**D/C from TBI PROGRAM**
	SM is was/is in MEB & Discharged from Army		**Soldier is FFD from TBI perspective? *Yes No***
	FUNCTIONAL STATUS at Discharge: 1 2 3 4 5 6 7		

CONSULTS: ☐SP ☐OT ☐PT ☐AUDIOLOGY ☐OPTOMETRY ☐NEUROPSYCH ☐ IN-HOUSE BH

☐ OUTPATIENT BH ☐MENTIS ☐ NEUROLOGY ☐ MRI ☐ LABS _____

OTHER CONSULTS:_____

MEDICATIONS: ☐ BIGGS ☐ SFMC ☐ WBAMC ☐ PX MEDS NEEDED_____

FOLLOW-UP: 1 2 3 4 5 6 7 8 9 10 11 12 ☐DAYS ☐WEEKS ☐MONTHS

(☐ TBI ☐ PTSD ☐ JUMPSTART CANDIDATE ☐ D/C from TBI PROGRAM)