Please complete the attach Intake 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.

Western Region Initial TBI Screening (WRITBIS)

PART I - SOLDIER QUESTIONNAIRE

NAME FIRST LAST		SSN
DATE *(dd/mm/yyyy)*	UNIT	GRADE
DOB *(dd/mm/yyyy)*	EDUCATION *(circle one)* GED HIGH SCHOOL 2YR COLLEGE 4YR COLLEGE MASTERS DEGREE DOCTORAL DEGREE	
CONTACT NUMBER *(home or cell phone)*	HOME	CELL
OPERATION *(circle all that apply)* OIF OEF OTHER *(list)*	COMPONENT *(circle one)* ACTIVE RESERVE NATIONAL GUARD	
NUMBER OF COMBAT DEPLOYMENTS: ○ 1 ○ 2 ○ 3 ○ 4 or more		

1. DID YOU HAVE INJURIES FROM ANY OF THE FOLLOWING EVENTS DURING YOUR MOST RECENT DEPLOYMENT?

	YES	NO	HOW MANY TIMES?
A. FRAGMENT	○	○	_____
B. BULLETS	○	○	_____
C. VEHICULAR (MVA)	○	○	_____
D. BLAST *(any)*	○	○	_____
E. FALL	○	○	_____
F. BLOW TO THE HEAD	○	○	_____

2. DID ANY OF THE INJURIES DURING YOUR DEPLOYMENT RESULT IN ANY OF THE FOLLOWING?

	YES	NO
A. DAZED, CONFUSED, OR SEEING STARS	○	○
B. NOT REMEMBERING THE INJURY	○	○
C. LOSS OF CONSCIOUSNESS FOR < 30 MIN	○	○
D. LOSS OF CONSCIOUSNESS FOR > 30 MIN	○	○
E. INJURY TO THE HEAD	○	○
F. NONE OF THE ABOVE	○	○

3. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS FROM THE INJURIES NOTED IN #1? *(IF NO, LEAVE BLANK. IF YES, INDICATE BELOW WHEN YOU HAD THE SYMPTOMS. MARK ALL THAT APPLY.)*

	RIGHT AFTER INJURY	NOW
A. HEADACHE	○	○
B. DIZZINESS	○	○
C. MEMORY PROBLEMS	○	○
D. BALANCE PROBLEMS	○	○
E. RINGING IN EARS	○	○
F. IRRITABILITY	○	○
G. SLEEP PROBLEMS	○	○
H. OTHER *(specify)*: _____	○	○

MARK BELOW FOR EACH SYMPTOM THAT WAS A PROBLEM EVEN BEFORE YOUR INJURY OCCURRED.

→ ○
→ ○
→ ○
→ ○
→ ○
→ ○
→ ○
→ ○

4. A. IF THERE WAS A BLAST, WHAT WAS YOUR ESTIMATED DISTANCE FROM THE PRIMARY BLAST?

0-1 METER ○
1-5 METER ○
5-10 METER ○
10-20 METER ○
20-50 METER ○
MORE THAN 50 M ○
NOT SURE/UNKNOWN ○

5. WHAT DIRECTION DID THE BLAST COME FROM?

FROM THE FRONT	○	FROM THE RIGHT	○
FROM THE REAR	○	FROM THE LEFT	○
THE BLAST ORIGINATED FROM UNDER ME OR THE VEHICLE	○	FROM ABOVE	○

6. TYPE OF HELMET WORN: KEVLAR ○ CVC ○ NO HELMET ○ OTHER TYPE ○ ( )

7. DID THE HELMET STAY ON YOUR HEAD? YES ○ NO ○ N/A ○

8. WERE YOU SEEN BY A MEDIC AFTER THE INJURY? YES ○ NO ○ N/A ○

9. WHO ELSE KNOWS WHAT HAPPENED TO YOU FROM YOUR UNIT AT THE TIME OF THE INJURY EVENT?

NAME, RANK: _____ MAY WE CONTACT THIS PERSON? YES ○ NO ○

CONTACT PHONE: _____

10. HAVE YOU EVER HAD A CONCUSSION OR OTHER HEAD INJURY PRIOR TO THIS DEPLOYMENT? YES ○ NO ○

IF YES, HOW MANY? _____ NUMBER OF EACH? FALL: ___ SPORTS: ___ MCA: ___ MVA: ___ OTHER: ___

IF FROM PRIOR DEPLOYMENT, HOW MANY IN EACH?: BLAST ____ FALL: ____ MVA____ FRAGMENT ____ BULLETS ____

IF YOU HAVE ANY COMMENTS, WRITE ON THE REVERSE SIDE

INITIAL APPOINTMENT: 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:_____ SSN:_____ Male Female

Are you in the WTB? Yes/No If yes, note Nurse Case Manager's name & phone:_____
Referred by: SRP WTU Other _____ Are you in a Medical Board or think you will be in one within the next 6 months? YES/NO IF YES, What for:_____

WHERE DO YOU WANT TO PICK UP YOUR MEDICATIONS? ☐BIGGS ☐SFMC (FT BLISS) ☐WBAMC

☐FREEDOM'S CROSSING PX ☐MCAFEE ☐Other:_____

MEDICATION ALLERGIES? YES/NO IF YES, LIST:_____

LATEX ALLERGY? YES/NO HIGHEST LEVEL OF EDUCATION: Circle GED or High School. Add any others that apply: SOME COLLEGE BACHELLOR'S DEGREE MASTER'S DEGREE DOCTORAL DEGREE

LIST CURRENT MEDICATIONS (Circle those that need a refill.): (If no meds, 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.
IS THERE DOMESTIC VIOLENCE IN YOUR HOME? YES/NO DO YOU FEEL DEPRESSED? YES/NO

DO YOU DRINK? YES/NO IF YES: BEER WINE LIQUOR HOW MUCH PER WEEK?_____
TOBACCO USE? YES/NO IF YES: CIGARETTES CIGARS CHEW. QUANTITY:_____

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, Describe: _____

_____

_____

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

HEADACHES

HISTORY (Check or Circle)

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

DID YOU HAVE HEADACHES BEFORE JOINING THE ARMY OR IN CHILDHOOD? ☐ YES ☐ NO

DO YOU MOTHER/FATHER/SISTER/BROTHER (Circle one) HAVE SEVERE HEADACHES? ☐ YES ☐ NO

DESCRIPTION (Circle or Check)

IN THE LAST 3 MONTHS YOUR HEADACHES ARE? ☐ *IMPROVING* ☐ *WORSENING* ☐ *STAYING THE SAME*

HOW DO THE SEVERE HEADACHES START? ☐ *SLOW* ☐ *QUICK*

WHERE ARE THE HEADACHES? _____

HOW DO YOU DESCRIBE YOUR HEADACHES? ☐ *THROBBING/POUNDING* ☐ *SHARP/PIERCING* ☐ *DULL/ACHING*

☐ *LIKE A BAND WRAPPED AROUND THE HEAD*

HOW BAD ARE YOUR WORST HEADACHES FROM 0 TO 10? *0 1 2 3 4 5 6 7 8 9 10*

IF YOU GET 2 TYPES OF HEADACHES, HOW BAD ARE THE LESS STRONG HEADACHES? *0 1 2 3 4 5 6 7 8 9 10*

How long do the WORST headaches last? _____ *How long do the LESS STRONG headaches last?* _____

HOW OFTEN DO YOU HAVE MODERATE/SEVERE HEADACHES? _____ *PER DAY OR (Example: 2-3 PER DAY)*
_____ *PER WEEK OR* _____ *PER MONTH OR* _____ *PER YEAR*

How often do you get the less strong headaches? _____

WHAT HELPS/WHAT HURTS? (Circle or Check)

HEADACHES GET WORSE? ☐ With laying down. ☐ With bright light. ☐ With noise. ☐ With odors.

DOES LIGHT BOTHER YOU? YES/NO IF YES, ☐ *WITH HEADACHES ONLY* ☐ *EVEN WITHOUT HEADACHES*

WHAT HELPS YOUR HEADACHES? ☐*Laying Down* ☐*Sleep* ☐*Reducing Stimulation* ☐ *Massage Neck/Temples*

☐ *Medication* ☐ *Darkness.* *LIST MEDICATIONS THAT HELP (Even if only a little bit):* _____

_____

WHAT HAVE YOU TRIED THAT DID NOT HELP? (List medications, acupuncture, etc.) _____

_____

DO YOU NOTICE ANYTHING STRANGE JUST BEFORE YOUR HEADACHES START? (like ☐ *mouth/hand numbness,*

☐ *vision changes,* ☐ *nausea, etc)?* ☐ NO *IF "Yes" but NOT LISTED, WHAT IS IT?* _____

WHICH OF THE FOLLOWING CAN HAPPEN WHEN YOU HAVE A HEADACHE? ☐*NAUSEA* ☐*VOMITING*

☐*RED EYES* ☐*RUNNY NOSE* ☐*WATERY EYES* ☐*Other:*_____

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

CIRCLE OR CHECK EACH ITEM THAT APPLIES TO YOU.

I Have Poor Concentration: ☐Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐Always

Is your main problem with concentration following conversations? ☐Yes ☐No.

My Poor Concentration Causes Significant Problems at: ☐ Work ☐ With Significant Other/Spouse

I Am Irritable: ☐Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐Always

Irritability Causes Significant Problems at: ☐ Work ☐ With Significant Other/Spouse

I Have Trouble Speaking: ☐ Stuttering ☐ Slurring Words ☐ I Don't Always Make Sense

I Have Memory Problems: ☐Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐Always

☐Forget Names ☐Forget Conversations ☐Can't Remember the Right Word ☐Losing Items

I Feel Anxious/Worry: ☐Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐Always

If you have anxiety/worry, please rate severity from 0-10 with 10 being the worst:_____

Trouble Thinking/Understanding?: ☐Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐Always

I Get Dizzy: ☐Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐Always

If you get dizzy, then check how: ☐ With Headache ☐ With Exertion ☐ Comes Randomly

Trouble with Vision?: ☐Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐Always

What type of problems do you get: _____If you get headaches(HA), do you have blurry/double vision ONLY WITH HA? YES/NO (Circle one)

My Sense of Smell is Greatly Decreased or Gone: ☐Yes ☐ No

I Have Balance Issues: ☐Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐Always

Only with headaches? ☐ Yes ☐ No Do you avoid closing your eyes in the shower because you might lose your balance? Yes/No

I Have Difficulty Sleeping? ☐ Rarely ☐ Sometimes ☐ Frequently **Total Hours of Sleep/Night**____

Trouble falling asleep? Yes/No. Wake up too much? Yes/No. Wake up too early? Yes/No

Nightmares?: Yes/No. If yes, how often? ☐ Rarely ☐Sometimes ☐Most Nights ☐Every Night

During Sleep I: ☐ Yell/Scream ☐ Punch/Kick ☐ Sleep Walk.

Name all medications that helped you sleep:_____

Name all medications tried that did not help you:_____

Ringing in Your Ears in the Last 3 Months? Yes/No.

If yes, how often? ☐Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐Always

Does the ringing interfere with your work? ☐Yes ☐ No Does it hurt? ☐Yes ☐ No

I Fatigue with Exercise Too Quickly! ☐Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐Always

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

Please list your deployments below (Where, from when to when, & job duty):

1st: Where:_____ When: _____ Job Duty/MOS _____
2nd: Where:_____ When: _____ Job Duty/MOS _____
3rd: Where:_____ When: _____ Job Duty/MOS _____
4th: Where:_____ When: _____ Job Duty/MOS _____
5th: Where:_____ When: _____ Job Duty/MOS _____

STOP. STOP. STOP. STOP. STOP. STOP. STOP STOP. STOP. STOP. STOP. STOP. STOP

FOR STAFF ONLY

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

RESPECT-MIL POSITIVE SCREEN: ☐ PTSD ☐ DEPRESSION