

TBI Assessment

Clinician's Information

Name:

Title:

License Number:

Contact Information:

Patient Information

Name:

Age:

Date of Birth:

Date of Test:

Introduction

Brief description of test:

Purpose of test:

Part 1: Initial Evaluation

Observation of Physical Symptoms:

Headaches

Dizziness

Fatigue

Speech Problems

Cognitive Symptoms:

Memory Loss

Difficulty Concentrating

Confusion

Part 2: Glasgow Coma Scale

Eye Opening Response

Verbal Response

Motor Response

Total Score:

Part 3: Neurological Examination

Motor Skills and Coordination:

Balance

Coordination

Strength

Sensory Function:

Vision

Hearing

Touch Sensitivity

Part 4: Imaging Tests

CT Scan Ordered

MRI Ordered

Results:

Part 5: Cognitive and Emotional Assessment

Cognitive Testing:

Short-term Memory

Problem-solving Skills

Emotional Assessment:

Mood Swings

Anxiety

Depression

Conclusion

Performance Summary:

Behavioral Observations:

Clinician's Observations and Comments:

Clinician's Signature

Date:

Patient Consent

I, _____, hereby consent to the TBI assessment as described above.

Patient Signature

Date:

Physician Signature

Name:

Date: