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

<table>
<thead>
<tr>
<th>NAME</th>
<th>FIRST</th>
<th>SSN</th>
</tr>
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<tbody>
<tr>
<td>LAST</td>
<td></td>
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<table>
<thead>
<tr>
<th>DATE (dd/mm/yyyy)</th>
<th>UNIT</th>
<th>GRADE</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>DOB (dd/mm/yyyy)</th>
<th>EDUCATION (circle one)</th>
<th>GED</th>
<th>HIGH SCHOOL</th>
<th>2YR COLLEGE</th>
<th>4YR COLLEGE</th>
<th>MASTERS DEGREE</th>
<th>DOCTORAL DEGREE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CONTACT NUMBER (home or cell phone)</th>
<th>HOME</th>
<th>CELL</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>OPERATION (circle all that apply)</th>
<th>OIF</th>
<th>OEF</th>
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<thead>
<tr>
<th>OTHER (list)</th>
<th>COMPONENT (circle one)</th>
<th>ACTIVE</th>
<th>RESERVE</th>
<th>NATIONAL GUARD</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NUMBER OF COMBAT DEPLOYMENTS:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4 or more</th>
</tr>
</thead>
</table>

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

- A. FRAGMENT
- B. BULLETS
- C. VEHICULAR (MVA)
- D. BLAST (any)
- E. FALL
- F. BLOW TO THE HEAD

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>HOW MANY TIMES?</th>
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2. DID ANY OF THE INJURIES DURING YOUR DEPLOYMENT RESULT IN ANY OF THE FOLLOWING?

- 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.)

- A. HEADACHE
- B. DIZZINESS
- C. MEMORY PROBLEMS
- D. BALANCE PROBLEMS
- E. RINGING IN EARS
- F. IRRITABILITY
- G. SLEEP PROBLEMS
- H. OTHER (specify):

<table>
<thead>
<tr>
<th>RIGHT AFTER INJURY</th>
<th>NOW</th>
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<tbody>
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</table>

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
- FROM ABOVE

THE BLAST ORIGINATED FROM UNDER ME OR THE VEHICLE

6. TYPE OF HELMET WORN:

- Kevlar
- CVC
- NO HELMET
- OTHER TYPE

7. DID THE HELMET STAY ON YOUR HEAD?

- YES
- NO

8. WERE YOU SEEN BY A MEDIC AFTER THE INJURY?

- YES
- NO

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

<table>
<thead>
<tr>
<th>NAME, RANK:</th>
<th>MAY WE CONTACT THIS PERSON?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
</tr>
</tbody>
</table>

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: __体育__

SPORTS: __NCA__

MVA: __MVA__

OTHER: __OTHER__

IF FROM PRIOR DEPLOYMENT, HOW MANY IN EACH?

BLAST: __BLAST__

FALL: __FALL__

MVA: __MVA__

FRAGMENT: __FRAGMENT__

Bullets: __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 BACHELOR’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:

____________________________________________________ ________________________________
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)


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/Temperles

□ 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: _______________________

Page 2 of 5 (SCS 12-29-11)
<table>
<thead>
<tr>
<th><strong>CIRCLE OR CHECK EACH ITEM THAT APPLIES TO YOU.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I Have Poor Concentration:</strong> □Never □Rarely □Sometimes □Frequently □Always</td>
</tr>
<tr>
<td>Is your main problem with concentration following conversations? □Yes □No.</td>
</tr>
<tr>
<td>My Poor Concentration Causes Significant Problems at: □ Work □ With Significant Other/Spouse</td>
</tr>
<tr>
<td><strong>I Am Irritable:</strong> □Never □Rarely □Sometimes □Frequently □Always</td>
</tr>
<tr>
<td>Irritability Causes Significant Problems at: □ Work □ With Significant Other/Spouse</td>
</tr>
<tr>
<td><strong>I Have Trouble Speaking:</strong> □ Stuttering □ Slurring Words □ I Don’t Always Make Sense</td>
</tr>
<tr>
<td><strong>I Have Memory Problems:</strong> □Never □Rarely □Sometimes □Frequently □Always</td>
</tr>
<tr>
<td>□Forget Names □Forget Conversations □Can’t Remember the Right Word □Losing Items</td>
</tr>
<tr>
<td><strong>I Feel Anxious/Worry:</strong> □Never □Rarely □Sometimes □Frequently □Always</td>
</tr>
<tr>
<td>If you have anxiety/worry, please rate severity from 0-10 with 10 being the worst:</td>
</tr>
<tr>
<td><strong>Trouble Thinking/Understanding:</strong> □Never □Rarely □Sometimes □Frequently □Always</td>
</tr>
<tr>
<td><strong>I Get Dizzy:</strong> □Never □Rarely □Sometimes □Frequently □Always</td>
</tr>
<tr>
<td>If you get dizzy, then check how: □ With Headache □ With Exertion □ Comes Randomly</td>
</tr>
<tr>
<td><strong>Trouble with Vision:</strong> □Never □Rarely □Sometimes □Frequently □Always</td>
</tr>
<tr>
<td>What type of problems do you get:</td>
</tr>
<tr>
<td>If you get headaches (HA), do you have blurry/double vision ONLY WITH HA? YES/NO (Circle one)</td>
</tr>
<tr>
<td><strong>My Sense of Smell is Greatly Decreased or Gone:</strong> □Yes □ No</td>
</tr>
<tr>
<td><strong>I Have Balance Issues:</strong> □Never □Rarely □Sometimes □Frequently □Always</td>
</tr>
<tr>
<td>Only with headaches? □ Yes □ No Do you avoid closing your eyes in the shower because you might lose your balance? Yes/No</td>
</tr>
<tr>
<td><strong>I Have Difficulty Sleeping:</strong> □Rarely □Sometimes □Frequently <strong>Total Hours of Sleep/Night</strong></td>
</tr>
<tr>
<td>Trouble falling asleep? Yes/No. Wake up too much? Yes/No. Wake up too early? Yes/No</td>
</tr>
<tr>
<td><strong>Nightmares?</strong>: Yes/No. If yes, how often? □Rarely □Sometimes □Most Nights □Every Night</td>
</tr>
<tr>
<td><strong>During Sleep I:</strong> □ Yell/Scream □ Punch/Kick □ Sleep Walk.</td>
</tr>
<tr>
<td>Name all medications that helped you sleep:</td>
</tr>
<tr>
<td>Name all medications tried that did not help you:</td>
</tr>
<tr>
<td><strong>Ringing in Your Ears in the Last 3 Months?</strong> Yes/No.</td>
</tr>
<tr>
<td>If yes, how often? □Never □Rarely □Sometimes □Frequently □Always</td>
</tr>
<tr>
<td>Does the ringing interfere with your work? □Yes □No Does it hurt? □Yes □No</td>
</tr>
<tr>
<td><strong>Fatigue with Exercise Too Quickly!</strong> □Never □Rarely □Sometimes □Frequently □Always</td>
</tr>
</tbody>
</table>
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