| **Traumatic Brain Injury (TBI)** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Guided Credible History Interview Template** | | | | | | | |
| Date of Interview: Click or tap here to enter text. | | Individual Conducting Interview: Click or tap here to enter text. | | | | | |
|  | | | | | | | |
| **IDENTIFYING INFORMATION** | | | | | | | |
| Legal Name of Child: Click or tap here to enter text. | | | | | | | |
| Birthdate: Click or tap to enter a date. | Age: Click or tap here to enter text. | Sex: Click or tap here to enter text. | | | Grade: Click or tap here to enter text. | | |
| Person Interviewed: Click or tap here to enter text. | | Relationship to Child: Click or tap here to enter text. | | | | | |
| Child Primarily Lives with: Click or tap here to enter text. | | | | | | | |
| Child’s Primary Care Physician: Click or tap here to enter text. | | | | | | | |
| Last time seen: Click or tap to enter a date. | Within 6 months | Within year | | Within 2 years | | Over 2 years | |
|  | | | | | | | |
| **DEVELPMENTAL HISTORY** | | | | | | | |
| (Information in this section can be gathered through a different developmental history form, if desired) | | | | | | | |
| Were there any complications during the pregnancy or birth? | | Yes | | | | No | |
| Explain: Click or tap here to enter text. | | | | | | | |
| Was there any use of alcohol, cigarettes, or drugs during pregnancy? | | Yes | | | | No | |
| Explain: Click or tap here to enter text. | | | | | | | |
| Did the child crawl by 9 months? | | | Yes | | | No | |
| Did the child walk by 18 months? | | | Yes | | | No | |
| Did your child speak single words by 15 months? | | | Yes | | | No | |
| Did your child use two-to-three word sentences by 24 months? | | | Yes | | | No | |
| Were there problems with balance or coordination? | | | Yes | | | No | |
| Were there problems with fine motor skills? (picking something up, buttons, feeding self) | | | Yes | | | No | |
| Were there problems with fine motor skills? (picking something up, buttons, feeding self) | | | Yes | | | No | |
| Explain: Click or tap here to enter text. | | | | | | | |
|  | | | | | | | |
| **MEDICAL HISTORY** | | | | | | | |
| (Information in this section can be gathered through a different developmental history form, if desired) | | | | | | | |
| Major Illnesses: | | | | | | | |
| Hospitalization/Surgeries: | | | | | | | |
| Accidents/Injuries: | | | | | | | |
| Explain: Click or tap here to enter text. | | | | | | | |
|  | | | | | | | |
| **Hearing:** | | | | | | | |
| Does your child have any known hearing problems, including frequent ear infections or tubes placed? | | | | | | | |
| Do you have any concerns about your child’s hearing? | | | Yes | | | No | |
| Explain: Click or tap here to enter text. | | |  | | |  | |
| **Vision:** | | |  | | |  | |
| Do you have any concerns about your child’s vision? (Please note if glasses have been prescribed and if they are worn). | | | Yes | | | No | |
| Explain: Click or tap here to enter text. | | | | | | | |
| **Motor:** | | | | | | | |
| Does your child have any physical disabilities? | | | Yes | | | No | |
| Explain: Click or tap here to enter text. | | | | | | | |
| Are there any restrictions for activity? | | | Yes | | | No | |
| Explain: Click or tap here to enter text. | | |  | | |  | |
| **Neurological:** | | | | | | | |
| Has your child ever had seizures? | | | Yes | | | No | |
| Date of last seizure: | | | | | | | |
| Explain: Click or tap here to enter text. | | | | | | | |
| Does your child have frequent headaches? | | | Yes | | | No | |
| Explain: Click or tap here to enter text. | | | | | | | |
| Has your child ever had a head injury or concussion? | | Yes | | | | No | |
| After injury: | | Dizziness? | | | | Memory Problems? | |
|  | | Headaches? | | | | Fatigue? | |
| Was a physician seen for the injury? | | Yes | | | | No | |
|  | | Who: | | | | | |
| Hospitalized? | | Yes | | | | | No |
|  | | Where? | | | | | |
| Does your child have sleeping/bedtime concerns? | | Yes | | | | | No |
| Explain: Click or tap here to enter text. | | | | | | | |
| **Medication:** | | | | | | | |
| Has your child been diagnosed with any medical or mental health conditions? | | Yes | | | | | No |
| Is your child currently taking medications (prescription and/or over-the-counter)? | | Yes | | | | | No |
| List Name, Dose, and Time: Click or tap here to enter text. | | | | | | | |

| **INJURIES AND ILLNESSES RELATED TO TBI** | | |
| --- | --- | --- |
| Please check all that apply. | | |
| **Injury or Illness** | **Age** | **Outcomes (check all the apply)** |
| Blow to head (from sports, playing, biking, falling, getting hit by an object, etc.) | At what age? | Concussion  Loss of consciousness \*for how long?  Coma \*for how long?  Confusion or altered state of mind  Medical attention sought  Missed school  Resulted in no problems |
| Whiplash | At what age? | Concussion  Loss of consciousness \*for how long?  Coma \*for how long?  Confusion or altered state of mind  Medical attention sought  Missed school  Resulted in no problems |
| Car crash (resulting in any degree of injury or lack of injury) | At what age? | Concussion  Loss of consciousness \*for how long?  Coma \*for how long?  Confusion or altered state of mind  Medical attention sought  Missed school  Resulted in no problems |
| Assault/violence (child abuse, fights, firearm injury) | At what age? | Concussion  Loss of consciousness \*for how long?  Coma \*for how long?  Confusion or altered state of mind  Medical attention sought  Missed school  Resulted in no problems |
| Sustained high fever | At what age? | Concussion  Loss of consciousness \*for how long?  Coma \*for how long?  Confusion or altered state of mind  Medical attention sought  Missed school  Resulted in no problems |
| Brain tumor | At what age? | Concussion  Loss of consciousness \*for how long?  Coma \*for how long?  Confusion or altered state of mind  Medical attention sought  Missed school  Resulted in no problems |
| Anoxia (definition: lack of oxygen; caused by such events as a near- drowning experience  or suffocating experience) | At what age? | Concussion  Loss of consciousness \*for how long?  Coma \*for how long?  Confusion or altered state of mind  Medical attention sought  Missed school  Resulted in no problems |
| Meningitis | At what age? | Concussion  Loss of consciousness \*for how long?  Coma \*for how long?  Confusion or altered state of mind  Medical attention sought  Missed school  Resulted in no problems |
| Encephalitis | At what age? | Concussion  Loss of consciousness \*for how long?  Coma \*for how long?  Confusion or altered state of mind  Medical attention sought  Missed school  Resulted in no problems |
| Seizures (e.g. epilepsy) | At what age? | Concussion  Loss of consciousness \*for how long?  Coma \*for how long?  Confusion or altered state of mind  Medical attention sought  Missed school  Resulted in no problems |
| Overdose of drugs or alcohol or inappropriate use of prescription drugs or over-the-counter medication | At what age? | Concussion  Loss of consciousness \*for how long?  Coma \*for how long?  Confusion or altered state of mind  Medical attention sought  Missed school  Resulted in no problems |
| **Additional Information** (when/where did incident occur, what type of medical intervention was sought, what symptoms occurred / what did you observe, when did your child start to feel better, were any accommodations needed at home or school, etc): Click or tap here to enter text. | | |

| **BEHAVIORS THAT CAN AFFECT LEARNING** | |
| --- | --- |
| **Learning Style or Behavior** | **Impact** |
| Focusing or maintaining attention | No Concern  Some Concern  High Concern  Used to be a concern |
| Getting started on activities, tasks, chores, homework, etc., on his/her own | No Concern  Some Concern  High Concern  Used to be a concern |
| Being understood (speech is easy to understand, speaks clearly) | No Concern  Some Concern  High Concern  Used to be a concern |
| Understanding others | No Concern  Some Concern  High Concern  Used to be a concern |
| Coping with changes or transitions | No Concern  Some Concern  High Concern  Used to be a concern |
| Letting go of one activity to attend to another | No Concern  Some Concern  High Concern  Used to be a concern |
| Reacting to simple problems | No Concern  Some Concern  High Concern  Used to be a concern |
| Monitoring own progress on homework, assignments, chores, and the like | No Concern  Some Concern  High Concern  Used to be a concern |
| Solving everyday problems (e.g. thinking of different options when something is not working for him/her) | No Concern  Some Concern  High Concern  Used to be a concern |
| Learning from past mistakes or behavior | No Concern  Some Concern  High Concern  Used to be a concern |
| Thinking before speaking or acting | No Concern  Some Concern  High Concern  Used to be a concern |
| Listening without interrupting others | No Concern  Some Concern  High Concern  Used to be a concern |
| Handling a change of plans | No Concern  Some Concern  High Concern  Used to be a concern |
| Demonstrating good judgment | No Concern  Some Concern  High Concern  Used to be a concern |
| Learning new things easily | No Concern  Some Concern  High Concern  Used to be a concern |
| Remembering day-to-day events | No Concern  Some Concern  High Concern  Used to be a concern |
| Explain: Click or tap here to enter text. | |

| **SYMPTOMS** | | |
| --- | --- | --- |
| If your child has experienced any of the following symptoms, rank the severity of those symptoms (1 = once weekly, 7 = daily, N/A = not a problem) | | |
| **Symptoms** | **Not a problem** | **Circle the number on the scale that best describes your child:** |
| Headaches and/or migraines (sudden, not responsive to medication, can last for more than a day) | N/A | 1  2  3  4  5  6  7 |
| Headaches and/or migraines (sudden, not responsive to medication, can last for more than a day) | N/A | 1  2  3  4  5  6  7 |
| Blackouts/fainting | N/A | 1  2  3  4  5  6  7 |
| Confusion | N/A | 1  2  3  4  5  6  7 |
| Blank staring/daydreaming | N/A | 1  2  3  4  5  6  7 |
| Dizziness | N/A | 1  2  3  4  5  6  7 |
| Change in vision (blurred or double, depth perception difficulties) | N/A | 1  2  3  4  5  6  7 |
| Fatigue (tires easily, is often tired) | N/A | 1  2  3  4  5  6  7 |
| Seizures | N/A | 1  2  3  4  5  6  7 |
| Slurred speech | N/A | 1  2  3  4  5  6  7 |
| Has trouble finding the “right” word when talking | N/A | 1  2  3  4  5  6  7 |
| Noise sensitivity (easily upset by loud noises or specific sounds like a ticking clock) | N/A | 1  2  3  4  5  6  7 |
| Light sensitivity (easily upset by bright or strobe lights) | N/A | 1  2  3  4  5  6  7 |
| Sleepiness (has trouble staying awake during the day) | N/A | 1  2  3  4  5  6  7 |
| Mood swings (unusual or quick changes among sadness, happiness, depression, anxiety, anger) | N/A | 1  2  3  4  5  6  7 |
| Explain: Click or tap here to enter text. | | |

| **SUPPORT SERVICES** | | | |
| --- | --- | --- | --- |
| Is your child currently receiving any of the following services? Check all that apply.  If “yes,” please check whether they are provided through the school, are being provided privately, or both. | | | |
| **Occupational therapy** | No  Yes  If Yes, please check whether these services are provided through a  School-supported specialist (the school pays for the specialist)  Private specialist (you and/or your insurances pays) | | |
| **Physical therapy** | No  Yes  If Yes, please check whether these services are provided through a  School-supported specialist (the school pays for the specialist)  Private specialist (you and/or your insurances pays) | | |
| **Speech-language therapy** | No  Yes  If Yes, please check whether these services are provided through a  School-supported specialist (the school pays for the specialist)  Private specialist (you and/or your insurances pays) | | |
| **Counseling / Psychological** | No  Yes  If Yes, please check whether these services are provided through a  School-supported specialist (the school pays for the specialist)  Private specialist (you and/or your insurances pays) | | |
| **Other Explain:** Click or tap here to enter text. | No  Yes  If Yes, please check whether these services are provided through a  School-supported specialist (the school pays for the specialist)  Private specialist (you and/or your insurances pays) | | |
| Is your child having difficulties with school performance? Please describe: | | | |
| Has your child ever been privately evaluated for learning or behavioral concerns? | | Yes | No |
| If Yes, when and where was the evaluation completed?  Click or tap here to enter text. | | | |
| Has your child ever been evaluated for special education services at school? | | Yes | No |
| If Yes, at what age was your child first evaluated?  Click or tap here to enter text. | | | |
| Additional Concerns:  Click or tap here to enter text. | | | |
| Signature of person completing this form: Click or tap here to enter text. | | | Date: Click or tap to enter a date. |
| Role/Position: Click or tap here to enter text. | | |  |