| **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 experienceor 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 [ ]  YesIf 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 [ ]  YesIf 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 [ ]  YesIf 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 [ ]  YesIf 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 [ ]  YesIf 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. |  |