Name:_____ Date:_____

Below are five statements with which you may agree or disagree. Using the scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

1 = strongly disagree
2 = disagree
3 = slightly disagree
4 = neither agree nor disagree
5 = slightly agree
6 = agree
7 = strongly agree

_____ 1. In most ways my life is close to my ideal.
_____ 2. The conditions of my life are excellent.
_____ 3. I am satisfied with my life.
_____ 4. So far I have gotten the important things I want in life.
_____ 5. If I could live my life over, I would change almost nothing.

The Ottawa Hospital | L'Hôpital d'Ottawa

Patient Health Questionnaire (PHQ-9 & GAD-7)

INSTRUCTIONS

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Use the scale at right as a basis for your answers.

NAME: _____

Age: Sex: ☐ M ☐ F DATE:

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1 Little interest or pleasure in doing things.				
2 Feeling down, depressed or hopeless.				
3 Trouble falling asleep, staying asleep, or sleeping too much.				
4 Feeling tired or having little energy.				
5 Poor appetite or overeating.				
6 Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down.				
7 Trouble concentrating on things such as reading the newspaper or watching television.				
8 Moving or speaking so slowly that other people could have noticed or being so fidgety or restless that you have been moving around a lot more than usual.				
9 Thinking that you would be better off dead or that you want to hurt yourself in some way.				
10 Feeling nervous, anxious or on edge.				
11 Not being able to stop or control worrying.				
12 Worrying too much about different things.				
13 Trouble relaxing.				
14 Being so restless that it is hard to sit still.				
15 Becoming easily annoyed or irritable.				
16 Feeling afraid as if something awful might happen.				

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

FRANÇAIS AU VERSO

Rivermead Post Concussion Symptoms Questionnaire

Modified (Rpq-3 And Rpq-13)[23] Printed With Permission: Modified Scoring System From Eyres 2005[24]

Name: Date:

After a head injury or accident some people experience symptoms that can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below please circle the number that most closely represents your answer.

0 = not experienced at all
1 = no more of a problem
2 = a mild problem
3 = a moderate problem
4 = a severe problem

Compared with **before** the accident, do you **now** (i.e., over the last 24 hours) suffer from:

	not experienced	no more of a problem	mild problem	moderate problem	severe problem
Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity (easily upset by loud noise)	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred vision	0	1	2	3	4
Light sensitivity (easily upset by bright light)	0	1	2	3	4
Double vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties? Please specify, and rate as above.

1.	0	1	2	3	4
2.	0	1	2	3	4

Administration only:

RPQ-3 *(total for first three items)*	
RPQ-13 *(total for next 13 items)*	

http://www.maa.nsw.gov.au/default.aspx?MenuID=148

Name: _____ Date: _____

Day-to-Day Experiences

Instructions: Below is a collection of statements about your everyday experience. Using the 1-6 scale below, please indicate how frequently or infrequently you currently have each experience. Please answer according to what really reflects your experience rather than what you think your experience should be. Please treat each item separately from every other item.

1	2	3	4	5	6
Almost Always	Very Frequently	Somewhat Frequently	Somewhat Infrequently	Very Infrequently	Almost Never

I could be experiencing some emotion and not be conscious of it until sometime later.	1	2	3	4	5	6
I break or spill things because of carelessness, not paying attention, or thinking of something else.	1	2	3	4	5	6
I find it difficult to stay focused on what's happening in the present.	1	2	3	4	5	6
I tend to walk quickly to get where I'm going without paying attention to what I experience along the way.	1	2	3	4	5	6
I tend not to notice feelings of physical tension or discomfort until they really grab my attention.	1	2	3	4	5	6
I forget a person's name almost as soon as I've been told it for the first time.	1	2	3	4	5	6
It seems I am "running on automatic," without much awareness of what I'm doing.	1	2	3	4	5	6
I rush through activities without being really attentive to them.	1	2	3	4	5	6
I get so focused on the goal I want to achieve that I lose touch with what I'm doing right now to get there.	1	2	3	4	5	6
I do jobs or tasks automatically, without being aware of what I'm doing.	1	2	3	4	5	6
I find myself listening to someone with one ear, doing something else at the same time.	1	2	3	4	5	6

Please turn over

1 Almost Always	2 Very Frequently	3 Somewhat Frequently	4 Somewhat Infrequently	5 Very Infrequently	6 Almost Never

I drive places on 'automatic pilot' and then wonder why I went there.	1	2	3	4	5	6
I find myself preoccupied with the future or the past.	1	2	3	4	5	6
I find myself doing things without paying attention.	1	2	3	4	5	6
I snack without being aware that I'm eating.	1	2	3	4	5	6

Please turn over

Appendix 11.1

Barrow Neurological Institute (BNI) Fatigue Scale*

Name: _____ **Date:** _____

Please rate the extent to which each of the items below has been a problem for you since your injury. You should chose only ONE number from 0–7 on the scale below when making your response.

0	1	2	3	4	5	6	7
Rarely a problem		*Occasional problem but not frequent*		*A frequent problem*		*A problem most of the time*	

1. How difficult is it for me to maintain my energy throughout the day? _____
2. How difficult is it for me to participate in activities because of fatigue? _____
3. How difficult is it for me to stay awake during the day? _____
4. How difficult is it for me to complete a task without becoming tired? _____
5. How difficult is it for me to stay alert during activities? _____
6. How difficult is it for me to build my energy level once I wake up in the morning? _____
7. How difficult is it for me to stay out of my bed during the day? _____
8. How difficult is it for me to stay alert when I am not involved in something? _____
9. How difficult is it for me to attend to something without becoming sleepy? _____
10. How difficult is it for me to last the day without taking a nap? _____

TOTAL: _____

11. Please circle your OVERALL level of fatigue since your injury:

0	1	2	3	4	5	6	7	8	9	10
No problem										*Severe problem*

* Borgaro SR, Gierok S, Caples H, Kwasnica C. Fatigue after brain injury: Initial reliability study of the BNI Fatigue Scale. *Brain Injury.* 2004;18:685–690. Reproduced with permission from the authors and Informa Healthcare.