ELEVATE Health Clinics, LLC

ACUITY BRAIN CENTER

Elevate Symptom Survey

Name _____ DOB _____ Date _____

Circle the number that best represents the severity of your symptoms <u>since your injury</u>

N/A = "not applicable" *3 = "mild"* *5 = "moderate"* *7 = "severe"* *10 = "very severe"*

											ACG
Since your injury has it been harder to shift your thinking from one thing to another?	N/A	1	2	3	4	5	6	7	8	9	10
Such As: have a hard time switching from one activity to another; get stuck on the same thought; leave a project and then come back to it; have obsessive thought.											
											ACG/PFC
Since your injury has it been harder to remember phone number, shopping list, names?	N/A	1	2	3	4	5	6	7	8	9	10
											ACG/PFC/TL
Since your injury has it been harder to remember things from your past like yesterday's dinner or first day of school?	N/A	1	2	3	4	5	6	7	8	9	10
											PFC
Since your injury has it been harder to focus, pay attention to work or what you are reading, keep organized or follow instructions?	N/A	1	2	3	4	5	6	7	8	9	10
Such As: easily distracted, careless mistakes, lack attention to details, procrastination, reads slow or forget what you read											
Since your injury have you noticed outbursts (verbal or physical) or having a shorter fuse?	N/A	1	2	3	4	5	6	7	8	9	10
Since your injury has it been harder to manage you time?	N/A	1	2	3	4	5	6	7	8	9	10
Since your injury has it been harder tell others what you are thinking, finding or saying correct words, frequently using the wrong word, difficulty saying words right)											
											PFC/TL
Since your injury has it been harder to share your emotions	N/A	1	2	3	4	5	6	7	8	9	10
											TL
Since your injury has it been harder to interact with others socially or emotionally	N/A	1	2	3	4	5	6	7	8	9	10
Such As: Lose temper, get easily annoyed, feel angry and resentful											
Since your injury has it been harder to understand what others are saying to you in a conversation?	N/A	1	2	3	4	5	6	7	8	9	10
											BG/TL
Since your injury have you noticed feeling anxious, nervous, afraid, on edge or tense?	N/A	1	2	3	4	5	6	7	8	9	10
Such As: Paranoid, situational anxiety, panic, muscle tension, headaches, sore muscles, obsessive worry or fear, concerned about performance at work or school, social anxiety, lump in throat.											
											PFC/BG
Since your injury have you noticed feeling less confident?	N/A	1	2	3	4	5	6	7	8	9	10
											BG/PL
Since your injury have you noticed it's hard to unwind or calm down	N/A	1	2	3	4	5	6	7	8	9	10
											DLS
Since your injury have you noticed feeling sad, depressed or 'blue'	N/A	1	2	3	4	5	6	7	8	9	10
											PL
Irritability	N/A	1	2	3	4	5	6	7	8	9	10
Difficulty reading a map or poor direction orientation	N/A	1	2	3	4	5	6	7	8	9	10
											COL
Since your injury have you been more clumsy, unsteady or do you fall more often?	N/A	1	2	3	4	5	6	7	8	9	10
Since your injury have you been more dizziness, had changes in vision or double vision?	N/A	1	2	3	4	5	6	7	8	9	10

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											OLC/SMS
Poor handwriting	N/A	1	2	3	4	5	6	7	8	9	10
Poor coordination	N/A	1	2	3	4	5	6	7	8	9	10
Motion sickness (riding in cars, boats, carousels, etc.)	N/A	1	2	3	4	5	6	7	8	9	10
											SMS
Since your injury have you been more sensitive to loud noises or bright lights?	N/A	1	2	3	4	5	6	7	8	9	10
Since your injury have you noticed problems with muscle weakness, numbness, or seizures?	N/A	1	2	3	4	5	6	7	8	9	10
											SL
Difficult to initiate and maintain sleep	N/A	1	2	3	4	5	6	7	8	9	10
Such As: Insomnia, nightmares, restless sleep											
											O
Headache	N/A	1	2	3	4	5	6	7	8	9	10
Difficulty with your normal exercise routine	N/A	1	2	3	4	5	6	7	8	9	10
Difficulty performing your normal work	N/A	1	2	3	4	5	6	7	8	9	10
Ringing in ears	N/A	1	2	3	4	5	6	7	8	9	10

Birth History: If you know of any abnormalities regarding your birth, please provide a brief description:

Developmental Milestones: If you know of any abnormalities regarding your childhood development, please describe:

Seizure or Stroke: If you have ever had any seizures or strokes in the past, please provide a brief description:

Treatment or Therapy: If you have received any treatment or therapy for the injury we are evaluating today, please describe:

Headache or Migraine: If you have recently or are currently experiencing headaches, please provide a brief description:

Mental Illness: If you have ever had any mental illness in the past, please provide a brief description:

Top Three: Please list the top three symptoms that cause you the most distress since your injury:

1.
2.
3.

Head Injuries: If you have ever had any other head injuries in the past, please provide a brief description of the incident: