RESTBI Questionnaire

This questionnaire was designed to assess your exposure to possible head trauma over the course of your lifetime. Please take a moment to reflect back to your childhood (to instances you either remember or were told about) up until present day to answer all of the following questions as accurately as possible.

Gender ( ) M ( ) F Age ___________

1) In your lifetime, were you ever an active member of the military?
   * If yes, please continue. If no, please continue to question 2.
   □ Yes
   □ No
   A Either in training or combat, did you ever experience a blow to the head resulting in one or more of the following symptoms?
       * If yes, check all that apply. If no, please continue to question 2.
       Date(s)
       i □ Being dazed, confused, disoriented or “seeing stars” at the time of the incident
           _____,_____,
       ii □ Not remembering the injury
           _____,_____,
       iii □ Experiencing headache, dizziness, nausea, irritability, or memory impairments following the incident
           _____,_____,
       iv □ Losing consciousness
           _____,_____,
       • Please estimate the date (month/year) of each incidence. Please list the date(s) in the space provided above next to each corresponding symptom that was experienced.

2) In your lifetime, have you ever been involved in an automobile/bicycle/horsing accident?
   * If yes, please continue. If no, please continue to question 3.
   □ Yes
   □ No
   A Did you ever experience a blow to the head and/or whiplash resulting in one or more of the following symptoms?
       * If yes, check all that apply. If no, please continue to question 3.
       Date(s)
       i □ Being dazed, confused, disoriented or “seeing stars” at the time of the incident
           _____,_____,
       ii □ Not remembering the injury
           _____,_____,
       iii □ Experiencing headache, dizziness, nausea, irritability, or memory impairments following the incident
           _____,_____,
       iv □ Losing consciousness
           _____,_____,
       • Please estimate the date (month/year) of each incidence. Please list the date(s) in the space provided above next to each corresponding symptom that was experienced.
3) In your lifetime, have you ever slipped and fallen, causing injury to your head or neck?
   * If yes, please continue. If no, please continue to question 4.
     □ Yes
     □ No
     A Did this occurrence cause a blow to the head resulting in one or more of the following symptoms?
       * If yes, check all that apply. If no, please continue to question 4.  
         Date(s)
         i  □ Being dazed, confused, disoriented or “seeing stars” at the time of the incident ___ , _____,
         ii □ Not remembering the injury ___ , _____,
         iii □ Experiencing headache, dizziness, nausea, irritability, or memory impairments following the incident ___ , _____,
         iv □ Losing consciousness ___ , _____,
       • Please estimate the date (month/year) of each incidence. Please list the date(s) in the space provided above next to each corresponding symptom that was experienced.

4) In your lifetime, have you ever had a physical altercation with somebody (ie victim of assault, domestic abuse, involved in fight, etc.)?
   * If yes, please continue. If no, please continue to question 5.
     □ Yes
     □ No
     A Did this lead to a blow to the head resulting in one or more of the following symptoms?
       * If yes, check all that apply. If no, please continue to question 5.  
         Date(s)
         i  □ Being dazed, confused, disoriented or “seeing stars” at the time of the incident ___ , _____,
         ii □ Not remembering the injury ___ , _____,
         iii □ Experiencing headache, dizziness, nausea, irritability, or memory impairments following the incident ___ , _____,
         iv □ Losing consciousness ___ , _____,
       • Please estimate the date (month/year) of each incidence. Please list the date(s) in the space provided above next to each corresponding symptom that was experienced.
5) In your lifetime, have you ever played any of the following sports?
   * If yes, please check all that apply. If no, please continue to question 6.
   - Football/Rugby
   - Soccer
   - Lacrosse/Hockey
   - Baseball/Softball
   - Basketball/Volleyball
   - Boxing/Wrestling/MMA
   - Adventure Sports (ie Skiing, Skateboarding, etc.)
   - Cheerleading/Gymnastics
   - Other

A While participating in any of these sports, did you ever experience a blow to the head resulting in one or more of the following symptoms?
   * If yes, check all that apply. If no, please continue to question 6.

   - Being dazed, confused, disoriented or “seeing stars” at the time of the incident
   - Not remembering the injury
   - Experiencing headache, dizziness, nausea, irritability, or memory impairments following the incident
   - Losing consciousness

   Please estimate the date (month/year) of each incidence. Please list the date(s) in the space provided above next to each corresponding symptom that was experienced.

6) Have you experienced any other instances where you hit your head or neck resulting in one or more of the following symptoms?
   * If yes, check all that apply. If no, please continue to question 7.

   - Being dazed, confused, disoriented or “seeing stars” at the time of the incident
   - Not remembering the injury
   - Experiencing headache, dizziness, nausea, irritability, or memory impairments following the incident
   - Losing consciousness

   Please estimate the date (month/year) of each incidence. Please list the date(s) in the space provided above next to each corresponding symptom that was experienced.

   Please explain: _____________________________________________________________________
7) Did you ever seek medical attention and receive a diagnosis for any of these injuries?
   □ Yes
   □ No
   • If yes, which instance (s)? __________________________________________________________

8) Did any of the above injuries require hospitalization?
   □ Yes
   □ No
   • If yes, which instance (s)? __________________________________________________________
   • If yes, for how long? ________________________________________________________________

9) If you ever suffered a blow to the head resulting in loss of consciousness, what was the longest amount of time you were unconscious for? ____________

---

Positive Screen
- Any blow to the head resulting in loss of consciousness (item iv)
- Head trauma resulting in disorientation at the time of the event coupled with an affirmative response to any of the other symptoms (affirmative responses to items i & ii or i & iii)

Total # of TBI: ________  # of TBI with LOC: ________  Hospitalization: ________
Age at youngest TBI: ________  Most recent TBI: ________  Longest LOC: ________

Other notes: ______________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

This “Retrospective Screening of Traumatic Brain Injury” (RESTBI) Questionnaire was developed in 2013 at Duke University’s Brain Imaging and Analysis Center in concordance with current CDC definition and guidelines for head trauma (2013). It was adapted from several existing head trauma screening tools (HELPS, OSU TBI-ID, and BTBIS) to comprehensively survey the general population on events spanning their lifetime. For more information contact Mark Sundman or Eric Hall at RESTBI.Questionnaire@gmail.com