1. Does participant/subject display the following TBI symptom or sign?
2. Headache  Yes  No  Unknown
3. Nausea  Yes  No  Unknown
4. Vomiting  Yes  No  Unknown
5. Balance problems  Yes  No  Unknown
6. Fatigue  Yes  No  Unknown
7. Sensitive to light  Yes  No  Unknown
8. Sensitive to noise  Yes  No  Unknown
9. Numbness/tingling  Yes  No  Unknown
10. Drowsiness  Yes  No  Unknown
11. Sleeping less than usual  Yes  No  Unknown
12. Sleeping more than usual  Yes  No  Unknown
13. Difficulty falling asleep  Yes  No
14. Feeling mentally foggy  Yes  No  Unknown
15. Feeling slowed down  Yes  No  Unknown
16. Difficulty concentrating  Yes  No  Unknown
17. Difficulty remembering  Yes  No  Unknown
18. Irritability  Yes  No  Unknown
19. Sadness  Yes  No  Unknown
20. More emotional  Yes  No  Unknown
21. Nervousness  Yes  No  Unknown
22. Other, specify  Yes  No  Unknown

## Additional Supplemental Elements:

These elements may be included if relevant to the study. For additional details like permissible values, see the data dictionary associated with this CRF**.**

* TBI symptom or sign category
* TBI symptom or sign rating code (adult only)
* TBI symptom worsens with cognitive activity indicator (adult only)
* TBI symptom worsens with physical activity indicator (adult only)
* Orientation to person result
* Orientation to place result
* Orientation to time result