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 Unknown
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.

1. TBI symptom or sign category:

Physical

Sleep

Cognitive

Emotional

Other

1. TBI symptom or sign rating code (*adult only*): 1 (Normal) 2 3 4 5 6 (Very Different)
2. TBI symptom worsens with cognitive activity *(adult only*): Yes No Unknown
3. TBI symptom worsens with physical activity *(adult only*): Yes No Unknown
4. Orientation to person result: Abnormal Normal
5. Orientation to place result: Abnormal Normal
6. Orientation to time result: Abnormal Normal