

## CNS FUNCTIONING ASSESSMENT

|  |       |                |     |
|--|-------|----------------|-----|
| Name:  |       | Date of Birth: | Age |
| Today's date:  | Time: | Diagnosis:     |     |
| Are you able to drive a motor vehicle?                     | Yes   | Partially      | No  |
| Are you able to work or study?                             | Yes   | Partially      | No  |
| Are you able to sustain a close relationship with someone? | Yes   | Partially      | No  |

Below is a list of problems.

How frequently are you currently bothered by them?

Please rate from 0 (not at all) to 10 (all the time).

If one or more of your parents had this, please check box under 'parents' and if the problem came on suddenly, please check box under suddenly.

| SENSORY                                 | Frequency<br>0 (not at all) to 10 (all the time) | Parents? | Sudden<br>Onset |
|---|--|----------|-----------------|
| Light, in general, or lights bother you |  |          |                 |
| Problems with sense of smell            |  |          |                 |
| Problems with vision                    |  |          |                 |
| Problems with hearing                   |  |          |                 |
| Problems with sense of touch            |  |          |                 |

| EMOTIONS  | Frequency<br>0 (not at all) to 10 (all the time) | Parents? | Sudden<br>Onset |
|---|--|----------|-----------------|
| Problems of sudden, unexplained changes in mood |  |          |                 |
| Problems of sudden, unexplained fearfulness     |  |          |                 |
| Problems of unexplained spells of depression    |  |          |                 |
| Problems of unexplained spells of elation       |  |          |                 |
| Problems with explosiveness                     |  |          |                 |
| Problems with suicidal thoughts or actions      |  |          |                 |

| CLARITY  | Frequency<br>0 (not at all) to 10 (all the time) | Parents? | Sudden<br>Onset |
|--|--|----------|-----------------|
| Feel 'foggy' and have problems with clarity                    |  |          |                 |
| Problems with following conversations (with good hearing)      |  |          |                 |
| Problems with confusion  |  |          |                 |
| Problems following what you are reading                        |  |          |                 |
| Realize you have no idea what you have been reading            |  |          |                 |
| Problems with concentration                                    |  |          |                 |
| Problems with attention  |  |          |                 |
| Problems with sequencing                                       |  |          |                 |
| Problems with prioritizing                                     |  |          |                 |
| Problems not finishing what you start                          |  |          |                 |
| Problems organizing your room, office, or paperwork            |  |          |                 |
| You cover up that you don't know what was said or asked of you |  |          |                 |

| ENERGY                        | Frequency<br>0 (not at all) to 10 (all the time) | Parents? | Sudden<br>Onset |
|-------------------------------|--|----------|-----------------|
| Problems with stamina         |  |          |                 |
| Fatigue during the day        |  |          |                 |
| Trouble sleeping at night     |  |          |                 |
| Problems awakening at night   |  |          |                 |
| Problems falling asleep again |  |          |                 |

| ACTIVATION OR ANXIETY      | Frequency<br>0 (not at all) to 10 (all the time) | Parents? | Sudden<br>Onset |
|----------------------------|--|----------|-----------------|
| Restlessness               |  |          |                 |
| Problems with Irritability |  |          |                 |
| Day Dreaming               |  |          |                 |
| Worrying                   |  |          |                 |
| Always Moving              |  |          |                 |
| Cold hands or feet         |  |          |                 |
| Palpitations               |  |          |                 |

**MEMORY**

|  | Frequency<br>0 (not at all) to 10 (all the time) | Parents? | Sudden<br>Onset |
|--|--|----------|-----------------|
| Forget what you have just heard                      |  |          |                 |
| Forget what you are doing, what you need to do       |  |          |                 |
| Problems with procrastination and lack of initiative |  |          |                 |

**MOVEMENT**

|  | Frequency<br>0 (not at all) to 10 (all the time) | Parents? | Sudden<br>Onset |
|--|--|----------|-----------------|
| Problems with paralysis of one or more limbs |  |          |                 |
| Problems focusing or converging the eyes     |  |          |                 |

**PAIN**

|                             | Frequency<br>0 (not at all) to 10 (all the time) | Parents? | Sudden<br>Onset |
|-----------------------------|--|----------|-----------------|
| Head pain that is steady    |  |          |                 |
| Head pain that is throbbing |  |          |                 |
| Shoulder and neck pain      |  |          |                 |
| Wrist pain                  |  |          |                 |
| Tender areas of muscles     |  |          |                 |
| All-over pain               |  |          |                 |
| Joint pain                  |  |          |                 |
| Other pain (please specify) |  |          |                 |

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