

NEUROBEHAVIORIAL SYMPTON CHECKLIST

Name _____ Date _____

Age _____ Sex _____ Education _____

Instructions: Please rate the following symptoms with regard to how much they have disturbed you in the last three months. For each item, circle the number that matches your answer.

USE THESE DESCRIPTIONS TO GUIDE YOUR RATINGS:

0 = None Rarely if ever present; not a problem at all

1 = Mild Occasionally present, but it does not disrupt activities; I can usually continue what I'm doing; it doesn't really concern me.

2 = Moderate Often present; occasionally disrupts my activities; I can usually continue what I'm doing with some effort; I feel somewhat concerned.

3 = Severe Frequently present and disrupts activities; I can only do things that are fairly simple or take little effort; I feel like I need help.

4 = Very severe Almost always present and I have been unable to perform at work, school or home due to this problem; I probably cannot function without help.

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|----|---|----------|----------|--------------|------------|-----------------|
| 1. | Feeling Dizzy | 0 (None) | 1 (Mild) | 2 (Moderate) | 3 (Severe) | 4 (very severe) |
| 2. | Loss of Balance | 0 | 1 | 2 | 3 | 4 |
| 3. | Poor coordination, clumsy | 0 | 1 | 2 | 3 | 4 |
| 4. | Headaches | 0 | 1 | 2 | 3 | 4 |
| 5. | Nausea | 0 | 1 | 2 | 3 | 4 |
| 6. | Vision Problems, blurring, trouble seeing | 0 | 1 | 2 | 3 | 4 |
| 7. | Sensitivity to light | 0 | 1 | 2 | 3 | 4 |
| 8. | Hearing difficulty | 0 | 1 | 2 | 3 | 4 |

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|-----|--|----------|----------|--------------|------------|-----------------|
| 9. | Sensitivity to noise | 0 (None) | 1 (Mild) | 2 (Moderate) | 3 (Severe) | 4 (very severe) |
| 10. | Numbness or tingling on parts of my body | 0 | 1 | 2 | 3 | 4 |
| 11. | Change in taste and/or smell | 0 | 1 | 2 | 3 | 4 |
| 12. | Loss of appetite or increased appetite | 0 | 1 | 2 | 3 | 4 |
| 13. | Poor concentration, can't pay attention, easily distracted | 0 | 1 | 2 | 3 | 4 |
| 14. | Forgetfulness, can't remember things | 0 | 1 | 2 | 3 | 4 |
| 15. | Difficulty making decisions | 0 | 1 | 2 | 3 | 4 |
| 16. | Slowed thinking, difficulty getting organized, can't finish things | 0 | 1 | 2 | 3 | 4 |
| 17. | Fatigue, loss of energy, getting tired easily | 0 | 1 | 2 | 3 | 4 |
| 18. | Difficulty falling or staying asleep | 0 | 1 | 2 | 3 | 4 |
| 19. | Feeling anxious or tense | 0 | 1 | 2 | 3 | 4 |
| 20. | Feeling depressed or sad | 0 | 1 | 2 | 3 | 4 |
| 21. | Irritability, easily annoyed | 0 | 1 | 2 | 3 | 4 |
| 22. | Poor frustration tolerance, feeling easily overwhelmed by things | 0 | 1 | 2 | 3 | 4 |