Brain
Health Clinic

The CNS Functioning Assessment

Name _____Today's Date _____

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 pick a number from 0-to-10. "0" means *Not at all*, and "9" means *All the time.*

If one or more of your parents had this, place a *P* in the column headed by "Parents?"

If the problem came on suddenly, put an *S* in the column head by "Suddenly?"

Complete only once

Sensory	**Frequency (0 - 9)**	**Parents?**	**Suddenly?**
Light, in general, or lights, bother you	_____	_____	_____
Problems with the sense of smell	_____	_____	_____
Problems with vision	_____	_____	_____
Problems with hearing	_____	_____	_____
Problems with the sense of touch	_____	_____	_____
Emotions			
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	_____	_____	_____

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	Frequency (0 - 9)	Parents?	Suddenly?
Clarity			
Feel "foggy" and have problems with clarity	____	____	____
Problems 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, paperwork	____	____	____
You cover up that you don't know what was said or asked of you	____	____	____
Energy			
Problems with stamina	____	____	____
Fatigue during the day	____	____	____
Trouble sleeping at night	____	____	____
Problems awakening at night	____	____	____
Problems falling asleep again	____	____	____
Activation or Anxiety			
Restlessness	____	____	____
Problems with irritability	____	____	____

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	Frequency (0 - 9)	Parents?	Suddenly?	
Day Dreaming	_____	_____	_____	
Worrying	_____	_____	_____	
Always moving	_____	_____	_____	
Cold hands or feet	_____	_____	_____	
Palpitations	_____	_____	_____	
Memory				
Forget what you have just heard	_____	_____	_____	
Forget what you are doing, what you need to do	_____	_____	_____	
Problems with procrastination and lack of initiative	_____	_____	_____	
Problems not learning from experience	_____	_____	_____	
Movement				
Problems with paralysis of one or more limbs		_____	_____	_____
Problems focusing or converging the eyes	_____	_____	_____	
Pain				
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 _____(specify)	_____	_____	_____	

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