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Center# Subject # Initials

Validation PoCS Rule

PoCS Questionnaire
Phone Follow-up

☐ 7 day Follow-Up ☐ 30 day Follow-Up ☐ 90 day Follow-Up

Date of trauma (yyyy/mm/dd): ___________________________

Dates and times of attempts: ____

____

Date reached (yyyy/mm/dd): ________________

Loss to follow-up ☐

1. **I would like to know whether you still have any symptoms from your head trauma?**

No ☐

Yes ☐ which ones :

____

____

____

2. **Do you still have pain related to your accident? If yes, which ones?** (if pain was already present before the accident, has it increased since then?)

   Cervical or dorsal pain: No ☐ Yes ☐

   Pain in the limbs: No ☐ Yes ☐

   Other pain: No ☐ Yes ☐ Specify :____

3. **Since your visit to the emergency department, have you consulted a doctor or specialist because of your condition (for 30 days and 90 days follow-up, ask since the last follow-up)?**

   No ☐ Yes ☐

   If yes, what kind of consultation?

☐ in Emergency department, planned (follow-up)

☐ in Emergency department, not planned

☐ in a walk-in clinic

☐ in a specialized clinic for concussions

☐ Telephone follow-up with a nurse of the trauma team

☐ with a family physician

☐ with a sport physician

☐ with another physician:__________________

(QUESTION 3 CONTINUED OVERLEAF)

☐ in rehabilitation: Physiotherapy and/or Ergotherapy and/or other: ______________________________

☐ with a neuropsychologist/ psychologist

☐ another consultation: ____

4. **What is your principal occupation?**
(If patient is a student, please ask if he/she works and check the student AND employed section).

Student ☐

☐ Full-time ☐ Part-time

Were studies continued as before the accident? ☐ Yes ☐ No

If not, what best describes your present studies?

☐ Full-time

☐ Part-time

☐ I no longer study

Employed ☐

☐ Full-time ☐ Part-time

Was the employment continued as before the accident? ☐ Yes ☐ No

If not, what best describes your present work habits?

☐ Full-time

☐ Part-time

☐ Light work / Changes in duties

☐ On a work stoppage

Does not apply ☐

Please explain :

☐ Retired

☐ Already on work leave before this accident

☐ Maternity leave

☐ On holiday

☐ Unemployed

☐ Welfare recipient

☐ Other : __________________________

5. a. **Did you return to your normal activities just as before the head trauma?**

No ☐ Yes ☐

b. **If not, is it due to your trauma to the head (vs. physical injuries related to the accident)?**

No ☐ Yes ☐

c. **On what activities other than work did your trauma to the head have an impact?**

☐ Sports

☐ Arts

☐ Reading

☐ Tasks on the computer / mobile devices

☐ Social Activities

☐ Driving

☐ Activities of daily living (eg, cleaning, cooking, etc.)

☐ Watch television

☐ Caring for children

☐ Other :______________________________

Center # Subject # Initials

6. The Rivermead Post-Concussion Symptoms Questionnaire*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all
1 = No more of a problem
2 = A mild problem
3 = A moderate problem
4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1. ____________________	0	1	2	3	4
2. ____________________	0	1	2	3	4

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

Total ______________________
Average ______________________