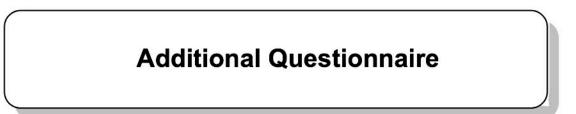
Online supplemental file 3. PoCS additionnal Questionnaire	2007		
$\langle P \rangle$	#Centre	Subject #	Initials
Programme de recherche 510()			
POCS Revearch Program			
Programme de recherche sur les Symptômes Post-Commotionnels Post-Concussion Symptoms Research Program			

Validation PoCS Rule



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

Dates and hours of attempts:

Date reached (yyyy/mm/dd): _____

Lost to Follow-Up

Questionnaire completed at:

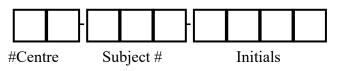
🗌 7 day Follow-Up
30 day Follow-Up
90 day Follow-Up

			$\left \right $	$-\Box$			
		#Centre	Subject #		Initia	ls	
Details of the accident : 1. Type of impact:							
A. Car :							
Has there been a collision? No	side in			Unknowr	ח 🗌		
motorcycle moose	(wall, tree, rock…)						
Did the vehicle flip or rollover No	? Yes 🗌		Unknown 🗌				
Did it leave the road? No □	Yes 🗌		Unknown 🗌				
Were you ejected? No 🗌	Yes 🗌		Unknown 🗌				
other, specify							
B. Other motorized vehicle:							
		_					
Motorcycle All-Terrain V	ehicle 🔄 Snowm	nobile 🗌 C	other, specify :_				-
Has there been a collision? NoYes: Did it leave the road?	 car motorcycle bicycle pedestrian object (wall, tr moose other animal other, specify 		Unknown 🗌				
]		Unknown 🗌				
Were you ejected? No 🗌	Yes 🗌		Unknown 🗌				
Was there a fall without a collision No	n, loss of control o Yes 🗌	r an uneven	road surface? Unknown 🗌				
other, specify							

		$\mathbf{H} \mathbf{F} \mathbf{F} \mathbf{F}$	
	#Centre	Subject #	Initials
C. D Bicycle :		2003000	
Has there been a collision?			
☐ moose ☐ other anim	l, tree, rock…)		
Were you ejected?			
No Yes		Unknown 🗌	
Was there a fall without a collision, loss of co NoYes	ntrol or an une	even road surface? Unknown 🗌	,
autre, précisez			
D. Pedestrian :			
Were you stuck by a vehicle? No Yes Car motorcycle bicycle other, spec	ify	Unknown 🗌	
Was there a fall?			
No Yes from his he	ight a height of _	Unknown [metres *	
		*(1 metre =	3 foots or 5 steps)
E. Sport :			
 hockey football/rugby soccer baseball rollerblading skiing/snowboarding ice skating sliding horseback riding skateboarding cheerleading other, specify 			

			$\frac{1}{2}$	
	#Centre	Subject #	Initials	
F. 🗌 Work accident :		•		
Could the accidentbest meet class sections A to E? NoYes)			
Have you received an object on the head? No 🗌 Yes 🗌		Unknown 🗌		
Have you been caught between two structures? NoYes		Unknown 🗌		
other, specify				-
G. Blows, battle and altercation:				
Was there a fight, or was the person hit? NoYes	Unkno	wn 🗌		
other, specify				
				_
H. Other type of impact/ Not mentioned				
Specify :				
				_
				_

				ı ——	<u> </u>			- 1		<u> </u>
							-			
2. Did	you suffer any head injuries?	5	#Centre	Sı	ubject ;	#		Initi	als	
	you suffer any field injuries?	ſ								
No 🗌										
Yes 🗌	Wounds/contusions to the h Wounds/contusions to the fa Fracture to the skull : Fracture to the base of the s Fracture to the face :	ace :	No No No No	Y Y Y	ies ies ies ies ies					
	other, speciy									
3. Did	you suffer any other injuries	?								
No 🗌										
Yes 🗌										
∏ F	ractures→	Lo Ril Up Lo Pe	oper spine wer spine os oper limbs wer limbs lvis her, specify							
<u> </u>	Sprain/traumatic tendinitis→		pper spine wer spine pper limbs	:		E S	/rist Ibow houldei ther	r		
		🗌 Lo	wer limbs	:		<u> </u> к	nkle nee ther			
		Ot	her, specify							
□ v	Vounds/contusions/hematoma	🗌 Ab	ck domen per limbs	:		E S	/rist Ibow houldei ther	r		
	Other, specify	🗌 Lo	wer limbs	:		_к _н	nkle nee ip ther			



- 4. Was there any other person injured or deceased in the accident? Specify.
 - None
 Spouse
 Children(s)
 Parent(s)
 Friend(s)
 Person in the other vehicle
 Unknown
 Other:
- 5. Were there any material losses caused by the accident (e.g. total loss of vehicle, etc.)? Specify :
 - None
 Car
 Motorcycle
 Bicycle
 Other

6. In everyday life, do you have family support?

Yes

Other

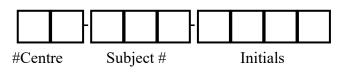
No		
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7. Medical history:

For the next questions, please answer yes or no:

A)	Do you have a medical history?	No 🗌	Yes
	If Yes, were you hospitalized within the last year?	No 🗌	Yes 🗌
B)	Do you have a history of head surgeries? No	Yes]
	If Yes, were you hospitalized within the last year?	No 🗌	Yes 🗌
C)	Do you have any psychiatric history?	No 🗌	Yes 🗌
	If Yes, were you hospitalized within the last year?	No 🗌	Yes 🗌
lf Y	'es, which one(s)?		
	 Depression Manic Depressive Psychosis disorder (t Schizophrenia Personality disorder General anxiety disorder Hyperactivity 	oipolar)	

 B. Do you take any medication prescribed by a doctor? Which one(s)? For what reason(s)? No Yes
If Yes : A) Antidepressants :
B) Mood stabilisers :
C) Anxiolytics:
D) Antipsychotics :
E) Analgesics : Acute pain
□Chronic pain (≥3 months)
F) Other :
 9. How would you describe your alcohol consumption before the accident, in everyday life? □ None □ Occasional □ Moderate (< 2 consumptions per day) □ Major (≥2 consumptions per day) □ The habit interferes with my work/social function
 10. How would you describe your drug use before the accident, in everyday life? None Occasional Moderate (each month) Major (each weak) The habit interferes with my work/social function
11. Have you had any academic difficulties (since elementary school) (e.g. repeated a grade, learning difficulties, hyperactivity, attention disorder, special classes, tutoring, reading/math/writing difficulties)?
If Yes, specify:



12. What is your level of education? (completed)

Elementary	Collegial Education Certificate
Secondary 1	Collegial Education Diploma
Secondary 2	Undergraduate certificate (First cycle)
Secondary 3	Baccalaureate
Secondary 4	Masters
Secondary 5	First year Doctorate
Professional Education Diploma	Doctorate (PhD)

13. What is your current work?

A) Employment status:	B) Length of employment:
	□ < 1 year
Executive	1 to 2 years
Self-employed	2 to 5 years
Seasonal worker	🗌 5 to 7 years
Not working	7 to 10 years
	10 to 15 years
	> 15 years

C) Occupation (primarily):

Office
Sitting (transportation)
Standing
Physical labour
Education
Health-daycare
Catering
Other:

14. Have you experienced any stressful situation in the 12 months preceding the accident (stressors)?

No 🗌 Yes	s 🗌
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<pre>#Centre Subject # Initials #Centre Subject # Initials 15. Did you suffer any head injuries in the past (or a concussion)? No Yes If Yes: A) Specify how many : If there were more than one, specify the type for each head injury, starting with the most recent to the oldest. If there were more than three, indicate for the last three only:</pre>	
1A. The type of trauma :	
mild Traumatic Brain Injury (TBI) (with loss of consciousness, amnesia, confusion or CT scan abnormalities)	
moderate TBI (hospitalized, non-intubated nor Intensive Care Unit)	
severe TBI (intubated, Intensive Care Unit)	
Unknown	
1B. Specify the exact year of TBI. If less than one year, specify the exact month :	
2A. The type of trauma :	
mild Traumatic Brain Injury (TBI) (with loss of consciousness, amnesia, confusion or CT scan abnormalities)	
moderate TBI (hospitalized, non-intubated nor Intensive Care Unit)	
severe TBI (intubated, Intensive Care Unit)	
2B. Specify the exact year of TBI. If less than one year, specify the exact month :	
3A. The type of trauma :	
mild Traumatic Brain Injury (TBI) (with loss of consciousness, amnesia, confusion or CT scan abnormalities)	
moderate TBI (hospitalized, non-intubated nor Intensive Care Unit)	
severe TBI (intubated, Intensive Care Unit)	
Unknown	

3B. Specify the exact year of TBI. If less than one year, specify the exact month :