College Survey for Students with Brain Injury

Name_____ Date _____

Interviewer_____

I. Demographics

1. Please fill in the following:

	(MM/DD/YYYY)
(1) Date of birth	___/___/_____
(2) Date of brain injury (please estimate if you are not certain)	___/___/_____

2. Sex (circle)
   Female Male

3. Are you currently enrolled in college? (circle)
   Yes No

4. How many years (yrs) of college have you completed? (circle)
   1yr 2yrs 3yrs 4 yrs 5yrs 6yrs 7+yrs

5. What years were you enrolled in college? (e.g. 2000-2004; 2006 to current)
   _____

II. Type of Brain Injury

6. What type(s) of brain injury do you have, and how old were you when each occurred?					
	Did you have this type of injury? (circle)		If yes, at what age? (circle)		
Traumatic brain injury (TBI)	Yes	No	0-11	12-17	18+
Stroke	Yes	No	0-11	12-17	18+
Brain tumor	Yes	No	0-11	12-17	18+
Multiple sclerosis (MS)	Yes	No	0-11	12-17	18+
Parkinson's disease (PD)	Yes	No	0-11	12-17	18+
Encephalitis	Yes	No	0-11	12-17	18+
Other (please specify) _____	Yes	No	0-11	12-17	18+

III. History of Injury

Please tell us a little bit about your brain injury.		
7. Please answer the following questions. If your answer is "yes," please indicate a length of time.		
	Yes/ No/ Don't know (circle)	If yes, approximately how long? (circle)
Were you in the hospital after your injury?	Yes/ No/ Don't know	1 2 3 4 semester(s) 1 2 3 4 5 6 day(s) 1 2 3 week(s) 1 2 3 4 5 6 7 8 9 10 11 month(s) 1 year Ongoing NA Other
Were you unconscious or in a coma after your injury?	Yes/ No/ Don't know	1 2 3 4 semester(s) 1 2 3 4 5 6 day(s) 1 2 3 week(s) 1 2 3 4 5 6 7 8 9 10 11 month(s) 1 year Ongoing NA Other
Did you, or are you now receiving any therapy or rehabilitation after your injury?	Yes/ No/ Don't know	1 2 3 4 semester(s) 1 2 3 4 5 6 day(s) 1 2 3 week(s) 1 2 3 4 5 6 7 8 9 10 11 month(s) 1 year Ongoing NA Other

Mary R. T. Kennedy & Miriam O. Krause. Email: kenne047@umn.edu

College Survey for Students with Brain Injury

Did you take a break from work or school after your injury?	Yes/ No/ Don't know	1 2 3 4 semester(s) 1 2 3 4 5 6 day(s) 1 2 3 week(s) 1 2 3 4 5 6 7 8 9 10 11 month(s) 1 year Ongoing NA Other
	Yes/ No/ Don't know (please circle)	If yes, approximately how long? (please circle)
Is brain injury your primary disability (Choose "N/A" for length of time)	Yes/ No/ Don't know	1 2 3 4 semester(s) 1 2 3 4 5 6 day(s) 1 2 3 week(s) 1 2 3 4 5 6 7 8 9 10 11 month(s) 1 year Ongoing NA Other
If you stated "other" for a length of time, please explain here. _____ _____		

Mary R. T. Kennedy & Miriam O. Krause. Email: kenne047@umn.edu

College Survey for Students with Brain Injury

IV. Effects of Brain Injury

7. What have been some effects of your brain injury? Please check all that apply, and indicate whether you have ever received therapy for each effect.

	Experienced the effect	Had therapy for the effect
Difficulty with academics, like studying, homework, tests	☐	☐
Problems making decisions	☐	☐
Difficulty with relationships	☐	☐
Physical impairment: arm/hands (for example, writing, etc.)	☐	☐
Mood changes	☐	☐
Anger	☐	☐
Physical impairment: legs (for example, walking)	☐	☐
Substance/alcohol abuse	☐	☐
Memory problems	☐	☐
Dizziness	☐	☐
Headaches	☐	☐
Attention problems	☐	☐
Fatigue	☐	☐
Organization problems	☐	☐
Depression	☐	☐
Difficulty maintaining friendships	☐	☐

Other (please specify)

_____

_____

Mary R. T. Kennedy & Miriam O. Krause. Email: kenne047@umn.edu

V. Therapies for Brain Injury

8. Which of the following therapies have you received BEACAUSE of your brain injury?			
	Please circle a response		
Psychological counseling	None	Past(completed)	Ongoing/current
Physical therapy	None	Past(completed)	Ongoing/current
Speech or language therapy	None	Past(completed)	Ongoing/current
Occupational therapy	None	Past(completed)	Ongoing/current
Support group	None	Past(completed)	Ongoing/current
Vocational counseling	None	Past(completed)	Ongoing/current
If "other," please specify _____ _____			

Mary R. T. Kennedy & Miriam O. Krause. Email: kenne047@umn.edu

VI. Your Student Experience

9. To what extent do you agree with each of the following statements about your experience as a college student since your brain injury?

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
I forget what has been said in class.	☐	☐	☐	☐	☐
I get overwhelmed when studying.	☐	☐	☐	☐	☐
I get overwhelmed in class.	☐	☐	☐	☐	☐
I get nervous before tests.	☐	☐	☐	☐	☐
I have trouble managing my time.	☐	☐	☐	☐	☐
I am late to class.	☐	☐	☐	☐	☐
I have trouble prioritizing assignments and meeting deadlines.	☐	☐	☐	☐	☐
Others do not understand my problems.	☐	☐	☐	☐	☐
I procrastinate on things I need to do.	☐	☐	☐	☐	☐
I have to review material more than I used to.	☐	☐	☐	☐	☐
I don't always understand instructions for assignments.	☐	☐	☐	☐	☐
I have trouble paying attention in class or while studying.	☐	☐	☐	☐	☐
I have fewer friends than before.	☐	☐	☐	☐	☐

Are you interested in meeting other students with brain injury? Are you interested in getting help from an educational specialist in brain injury? Indicate "Yes" or "No" here.

_____

_____

Mary R. T. Kennedy & Miriam O. Krause. Email: kenne047@umn.edu

VII. Your Use of Services

10. Since you have been in college (or when you were in college) did you use the following services because of your brain injury?

	Never heard or it	Heard of it but never used	Once	Occasionally	Sometimes	Pretty Often	All the time
Campus Disability Services	☐	☐	☐	☐	☐	☐	☐
Campus Veterans Services	☐	☐	☐	☐	☐	☐	☐
Campus Counseling Services	☐	☐	☐	☐	☐	☐	☐
Campus Medical Services	☐	☐	☐	☐	☐	☐	☐
A campus group for students with disabilities	☐	☐	☐	☐	☐	☐	☐
State Brain Injury Association	☐	☐	☐	☐	☐	☐	☐
State vocational rehabilitation services	☐	☐	☐	☐	☐	☐	☐
Other hospital or rehabilitation services	☐	☐	☐	☐	☐	☐	☐

If "other," please specify; or write any other comments here.

_____

_____

Mary R. T. Kennedy & Miriam O. Krause. Email: kenne047@umn.edu

VIII. Rating Services

11. For any service that you have used at least once, please tell us how useful you found the service.

	Completely useless	Somewhat useless	Somewhat useful	Extremely useful	N/A
Campus Disability Services	☐	☐	☐	☐	☐
Campus Veterans Services	☐	☐	☐	☐	☐
Campus Counseling Services	☐	☐	☐	☐	☐
Campus Medical Services	☐	☐	☐	☐	☐
A campus group for students with disabilities	☐	☐	☐	☐	☐
State Brain Injury Association	☐	☐	☐	☐	☐
State vocational rehabilitation services	☐	☐	☐	☐	☐
Other hospital or rehabilitation services	☐	☐	☐	☐	☐

If "other," please specify; or write any other comments here.

_____

_____

Mary R. T. Kennedy & Miriam O. Krause. Email: kenne047@umn.edu

IX. Life Changes

12. Please tell us about changes you have made in your life plans, goals, work situation, etc. since your brain injury.	
Have you changed what college or university you attend? If yes, what did you change it from and to?	_____ _____ _____
Have you changed your academic major? If yes, what was the change?	_____ _____ _____
Have you changed your academic status (e.g. full-time vs. part-time)? If yes, what was the change?	_____ _____ _____
Have you changed your career goal(s)? If yes, what was the change?	_____ _____ _____
Have you changed where you live? If yes, what was the change?	_____ _____ _____
Have you changed your current employment? If yes, what was the change?	_____ _____ _____
Comments: _____ _____ _____	

Mary R. T. Kennedy & Miriam O. Krause. Email: kenne047@umn.edu