

THOMAS M. BROD, M.D.  
SELF-REGULATION MEDICAL GROUP

**CNS Functioning Assessment** (L.Ochs)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

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

How **frequently** do you have problems in the following areas? Please pick a number from 0-to-10.  
"0" means *Not at all*, and "10" means *All the time*.

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

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

<b>Sensory</b>	<b>Frequency</b> (0 - 10)	<b>Parents?</b>	<b>Suddenly?</b>
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	_____	_____	_____
<b>Emotions</b>			
Problems of sudden, unexplained changes in mood	_____	_____	_____
Problems of sudden, unexplained fearfulness	_____	_____	_____
Problems of unexplained spells of depression/sadness	_____	_____	_____
Problems of unexplained spells of elation	_____	_____	_____
Problems with explosiveness	_____	_____	_____
Problems with suicidal thoughts or actions	_____	_____	_____
<b>Clarity</b>			
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 not finishing what you start	_____	_____	_____
Problems with sequencing	_____	_____	_____
Problems with prioritizing	_____	_____	_____

	<b>Frequency</b> (0 - 10)	<b>Parents?</b>	<b>Suddenly?</b>
Problems organizing your room, office, paperwork			
Problems with getting lost in daydreaming			
You cover up that you don't know what was said or asked of you			
<b>Energy</b>			
Problems with stamina			
Fatigue during the day			
Troubles falling asleep at night			
Problems awakening at night			
Problems falling asleep again			
<b>Activation/Anxiety</b>			
Restlessness			
Problems with Irritability			
Day Dreaming			
Worrying			
Always Moving			
Cold hands or feed			
Palpitations			
<b>Memory</b>			
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			
<b>Movement</b>			
Problems with paralysis of one or more limbs			
Problems focusing or converging the eyes			
<b>Pain</b>			
Head pain that is steady			
Head pain that is throbbing / migraines			
Shoulder and neck pain / upper back			
Wrist pain			
Tender areas of muscles			
All-over pain			
Joint pain			
Other pain (specify)			

**Other Problems**

	<b>Frequency</b> (0 - 10)	<b>Parents?</b>	<b>Suddenly?</b>
Problems with nausea			
Skin problems			
Problems with speech or articulation			
Dizziness			
Noise in ears (Tinnitus)			
Other Problems (list)			

