

The CNS Functioning Assessment

Name _____ Date of Birth _____ Age _____

Today's Date _____ Time _____ 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

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

	Frequency (0 - 9)	Parents?	Suddenly?
Sensory			
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	_____	_____	_____
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	_____	_____	_____
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)	_____	_____	_____