

The Center for the Advancement of Human Potential



CNS Functioning Assessment

Name _____ Date of Birth _____ Age _____

Today's Date _____ Diagnosis (if known) _____

Please circle your response

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

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

Sensory	<u>Frequency (0-10)</u>	<u>Parents?</u>	<u>Suddenly?</u>
Light, in general, or lights, bother you	_____	_____	_____
Problems with the sense of smell	_____	_____	_____
Problems with vision	_____	_____	_____
Problems with hearing	_____	_____	_____
Problems with sense of touch	_____	_____	_____

	<u>Frequency (0-10)</u>	<u>Parents?</u>	<u>Suddenly?</u>
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/temper outbursts	_____	_____	_____
Problems with irritability	_____	_____	_____
Problems with suicidal thoughts, urges 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've 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	_____	_____	_____
Problems with getting lost in daydreaming	_____	_____	_____
You cover-up that you don't know what was said or asked of you	_____	_____	_____

	<u>Frequency (0-10)</u>	<u>Parents?</u>	<u>Suddenly?</u>
Energy			
Problems with stamina	_____	_____	_____
Fatigue during the day	_____	_____	_____
Trouble getting to sleep at night	_____	_____	_____
Problems awakening at night	_____	_____	_____
Problems falling back to sleep once awake	_____	_____	_____
Not feeling rested after sleeping	_____	_____	_____
Memory			
Forget what you have just heard	_____	_____	_____
Forget what you are doing, what you need to do	_____	_____	_____
Getting lost in places that should be familiar	_____	_____	_____
Problems with procrastination and lack of initiative	_____	_____	_____
<u>Problems not learning from experience</u>	_____	_____	_____
Movement			
Problems with weakness or paralysis of limb/limbs	_____	_____	_____
Problems focusing or converging the eyes	_____	_____	_____
Problems with tremor or shaking	_____	_____	_____