# ICHIRF v1 Questionnaire

Please ensure you have read data privacy notice and signed consent before proceeding

**A. Part A**

1 . Enter your ID number _____ *(this will be issued once completed Questionnaire is returned)*

2 . Your Year of Birth - e.g. 1980

Year of Birth _____

3 . What is your nationality?

_____

4 . What is your gender?

- Male
- Female

5 . Current relationship status

- Single
- Married / civil partnership
- Living with partner (not married)
- Separated / divorced
- Widowed

6 . What is the highest degree or level of schooling you have completed?

- Primary or middle school (under or up to age 16 years)
- High school / secondary school / upper school (to year 12, secondary 5 or higher or to age 18 years)
- University / College degree
- Other postgraduate qualification e.g. diploma, etc.
- Trade qualification
- Other qualification

7 . Has your doctor or other medical professional ever diagnosed you with any of the following conditions that may have affected your school, sport or work performance?

| | | | |
|---|---|---|---|
| Attention deficit disorder (ADHD) | Yes | No | Not sure |
| Learning disorder e.g. dyslexia | Yes | No | Not sure |
| Hearing or Auditory processing problem | Yes | No | Not sure |
| Migraine or chronic headaches | Yes | No | Not sure |
| Depression, anxiety or other mental health problem | Yes | No | Not sure |
| Epilepsy or seizures | Yes | No | Not sure |
| Memory problems | Yes | No | Not sure |
| Alzheimer's disease or other dementia | Yes | No | Not sure |
| Permanent brain injury/damage from sport | Yes | No | Not sure |

8 . Are you currently employed?

Yes

If yes, what is your main occupation, or if at school, what year / grade level?

No

If no, are you retired?

Yes

No

9 . Are you currently receiving welfare, disability or injury insurance benefits from any source?

Yes

No

No, but have applied / planning to apply

○ Not applicable

10 . What is your CURRENT weight? *(select 1 only)*

○ Pounds Weight in pounds _____ lbs

○ Kilograms Weight in kilos _____ kgs

11 . If you have retired from sport, what was your approximate weight during your LAST YEAR of competition? *(select 1 only)*

○ Pounds Weight in pounds _____ lbs

○ Kilograms Weight in kilos _____ kgs

○ Not retired

○ Not a sportsman or sportswoman

12 . What is your CURRENT height (without shoes)? *(select 1 only)*

○ Inches Height in inches _____ ins

○ Centimetres Height in centimetres _____ cms

13 . With regard to sports activity, what is your dominant / preferred arm and leg?

| | | |
|---|---|---|
| Arm | ○ Right | ○ Left |
| Leg | ○ Right | ○ Left |

**B. Part B**

1 . What is your current level of physical activity?

○ Participate in organised or school sport

○ General physical activity on more than 3 days or more than 150 minutes per week (e.g. walking, jogging, gym, etc.)

What is your main type of exercise or physical activity? _____

○ Not physically active (exercise less than 3 days or less than 150 minutes total per week)

2 . What is your current sporting status?

○ Current student athlete

- Current amateur athlete
- Current professional athlete
- Retired amateur athlete
- Retired professional athlete

If retired from sport, main reason for retirement

- Not a sportsman or sportswoman - If not a sportsman or sportswoman, skip the next questions and go to question C1

3 . What is your main sport played?

- Australian Football
- Boxing
- Equestrian (show jumping, eventing, etc.)
- Football (soccer)
- GAA sports
- Horseracing (professional / amateur)
- Martial Arts
- Motor sports
- NFL and American Football
- Rugby Union
- Rugby League
- Snow & Alpine sports
- Wrestling
- Other sports

4 . For your main sport, at what age did you start taking part in regular or organised competition?

5 . For your main sport, what was / is your position on the field (e.g. hooker, full back, etc.) or sub-category within sport (e.g. jump jockey, 60kg boxer, F1 driver, slalom skier, etc.)

6 . For your main sport only, in your sporting career approximately how many rides, games, bouts, matches or events did you participate in?

School, age grade or underage sport

Local club, community, under 21 senior club, amateur or point to point jockey, amateur boxing, club level motor and alpine sport

Professional sport, including rugby provincial level, super rugby, county level competitions, professional jockey, professional boxing, national level motor and alpine sports

International or Olympic representative competitions, international level motor and alpine sport (or inter county competitions where no international competition exists e.g. GAA)

**C. Part C**

The following questions deal specifically with any concussions or head injuries that you may have had during your life and any risk factors for these injuries. If you cannot remember the exact number make an estimate or guess.

1 . Have you had any concussions or head injuries during your life NOT from sport (e.g. car accidents, falls, assaults etc.)?

Yes Approximate number of times

Approximate date of most recent injury

No

2 . Have you had any severe facial or dental injuries (e.g. facial fractures requiring surgery or specialist treatment, lost or permanently damaged teeth)?

Yes Number of times

No

3 . Has anyone in your family been diagnosed with dementia or Alzheimer's Disease?

Yes Please give details (i.e. which relative - mother, grandfather, etc.)

No

4 . Have you ever had a concussion from playing sport?

Yes

No - If no, skip the next questions and go to question D1

5 . How worried are you about the possible effect of concussion(s) or head injuries sustained during your career on your memory or thinking skills, as you get older?

*(select one only)*

| Not worried | | | Moderately worried | | | Very worried |
|---|---|---|---|---|---|---|
| ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 | ○ 6 | ○ 7 |

6 . We are trying to determine the total number of concussions (mild and severe) that you may have experienced in your career. The most obvious concussions are where you are knocked out cold or are unconscious. You may also have experienced milder concussions where you were briefly dazed or stunned after a collision or where you has some dizziness, confusion, balance problems, blurred vision, slowed reactions, nausea, difficulty concentrating or headache after a collision or impact.

| Please enter the details in the table below | Estimated number **of severe concussions where you were knocked out or unconscious** | Estimated number of times you had a **mild concussion where you were dazed** or stunned or had other symptoms (as above) but were NOT knocked out |
|---|---|---|
| School; age grade or underage sport | | |
| Local club, community, under 21 senior club, amateur or point to point jockey, amateur boxing, club level motor and alpine sport | | |
| Professional sport, including rugby provincial level, super rugby, county level competitions, professional jockey, professional boxing, national level motor and alpine sports | | |
| International or Olympic representative competitions, international level motor and alpine sport (or inter county competitions where no international exists, e.g. GAA) | | |

7 . From the concussions listed in the table above, approximately how many times did you return to the sport on the same day as the concussion occurred?

8 . If a doctor was on duty at the event or after, did you always tell them when you had a concussion or significant head knock?

○ No

○ Yes

9 . Answer as much as you can about the WORST CONCUSSION that you can remember as a result of your sport?

a. Year occurred ☐ b. Approximately how many days did it take to recover? ☐

c. Are you still affected by the concussion? ☐

e. Approximately how many games or events did you miss as a result of the concussion? ☐

10 . Do you think the sports concussions have had a permanent or lasting effect on your memory or thinking skills?

○ Yes

○ No - If no, skip the next questions and go to question D1

○ Unsure - If unsure, skip the next questions and go to question D1

1 . If 'yes' then...

What age were you when you started having symptoms? ☐

How many years between your retirement from professional sport and the development of these symptoms? ☐

12 . If yes, were these symptoms a continuation of the last concussion (i.e. never fully recovered) or were they 'new' symptoms that developed some time after your last concussion?

○ Continuation of symptoms from last concussion

○ New symptoms

○ Unsure

13 . What were the symptoms that alerted you to the problem?

*(select all that apply)*

☐ Memory problems

☐ Lack of Concentration/Attention

☐ Confusion

☐ Getting lost when driving/walking

☐ Personality change e.g. irritability, mood swings, explosive temper

☐ Loss of ability to do everyday tasks

☐ Other

14 . If you have already retired from sport, do family members or friends seem to think your memory is getting worse over time?

○ Yes ○ No ○ Not applicable

15 . If you have already retired from sport, do your memory problems interfere with your normal daily activities?

○ Yes ○ No ○ Not applicable

16 . Over the past month, did you have trouble controlling your anger to the point where you threatened someone with physical violence or got into a fight?

○ Yes ○ No

**D. Part D**

1 . Score yourself on the following symptoms, based on how you feel RIGHT NOW.

*(select one only from each row – all rows must be answered)*

| | none | | mild | | moderate | | severe |
|---|---|---|---|---|---|---|---|
| Headache | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| “Pressure in head” | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Neck Pain | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Nausea or vomiting | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Dizziness | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Blurred vision | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Balance problems | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Sensitivity to light | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Sensitivity to noise | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Feeling slowed down | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Feeling like “in a fog“ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

| | None | | Mild | | Moderate | | Severe |
|---|---|---|---|---|---|---|---|
| "Don't feel right" | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Difficulty concentrating | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Difficulty remembering | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Fatigue or low energy | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Confusion | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Drowsiness | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Trouble falling asleep | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| More emotional | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Irritability | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Sadness /Depressed | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Nervous or Anxious | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Difficulty speaking | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Explosive temper | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Lack of interest in life | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Difficulty with planning things | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

2 . Do any of these symptoms get worse with activity?

| | | |
|---|---|---|
| Physical activity | ○ Yes | ○ No |
| Mental activity | ○ Yes | ○ No |

**E. Part E**

1 . During the past month, how would you rate your sleep quality overall? *(select 1 only)*

- Fairly bad
- Average
- Fairly good

2 . During the past month, have you needed to take any sleeping pills or other tablets (e.g. prescribed or 'over the counter') to help you sleep?

- Yes
- No

3 . Have you ever been medically diagnosed with a sleep disorder (e.g. obstructive sleep apnoea, restless legs syndrome, etc.)

- Yes
- No

**F. Part F**

1 . In general, would you say your health is …

*(select 1 only)*

- Excellent
- Very good
- Good
- Fair
- Poor

2 . During the past one month, to what extent has any EMOTIONAL PROBLEMS (e.g. depression or sadness etc.) interfered with your normal social activities with family, friends, neighbours or groups?

- Not at all *(select 1 only)*
- Slightly
- Moderately
- Quite a bit
- Extremely

3 . During the past one month, how much did pain from previous sporting injuries interfere with your normal work (including both inside and outside the home)?

- ○ Not at all *(select 1 only)*
- ○ Slightly
- ○ Moderately
- ○ Quite a bit
- ○ Extremely

4 . How stressful do you consider your life to be?

- ○ Low *(select 1 only)*
- ○ Moderate
- ○ High

**G. Part G**

1 . Do you take medications prescribed by a doctor?

- ○ Yes List medications _____
- ○ No

2 . Do you drink alcohol?

- ○ Yes
- ○ No - If no, skip the next questions and go to question G6

3 . In the past month, on average how many days a week did/do you consume alcohol?

- ○ None
- ○ 1 - 2 days a week
- ○ 3 - 4 days a week
- ○ 5 - 7 days a week

4 . In the past month, on average how many alcoholic drinks per week did/do you consume?

- ○ None
- ○ 1 - 2 drinks
- ○ 3 - 5 drinks
- ○ 6 - 7 drinks
- ○ 8+ drinks

5 . Has your drinking ever resulted in any legal problems, club disciplinary measures, relationship problems or have you ever needed counselling or rehabilitation due to a drinking problem?

- Yes
- No

6 . How often do you use medications, alcohol, or other substances to help you relieve stress and relax?

*(select 1 only)*

- Frequently (several times a week)
- Occasionally (once or twice a week)
- Seldom (once or twice a month)
- Almost never
- Never

7 . In the past 12 months, did you take any of the drugs listed below more than once, to get high, to feel elated, to get a buzz, or to change your mood?

*Amphetamines speed, crystal meth Dexedrine, Ritalin, diet pills, rush THC, marijuana, cannabis, hashish, cocaine, crack steroids, GHB Valium, Xanax Ativan barbiturates, heroin morphine, methadone, opium, Demerol® codeine, Percodan, OxyContin, Vicodin, LSD, mescaline, PCP, angel dust, ecstasy MDA, MDMA ketamine, inhalants, glue, ether etc.*

- Yes
- No
- Do not wish to reply

8 . In the past 12 months, have you taken any performance enhancing drugs such as anabolic steroids?

- Yes
- No
- Do not wish to reply

**H. Part H**

1 . How would you describe your smoking history?

- Current smoker
- Ex-smoker
- Never smoked - If never smoked, skip the next questions and go to question I1

2 . Answer only if you are a current or ex-smoker

a. What age did you start smoking? ☐

b. If an ex-smoker, what age did you quit smoking? ☐

c. On average, how many cigarettes do / did you smoke a day? ☐

**I. Part I**

The following questions are related to your stress and mental well-being. Choose one response from the four given for each of the 7 questions. You should give an immediate response and do not try to think too long about the answers. You should answer how it CURRENTLY describes your feelings.

1 . I feel tense or 'wound up'?

- ○ Most of the time
- ○ A lot of the time
- ○ Occasionally
- ○ Not at all

2 . I get a sort of frightened feeling as if something awful is about to happen?

- ○ Very definitely and quite badly
- ○ Yes, but not too badly
- ○ A little, but it doesn't worry me
- ○ Not at all

3 . Worrying thoughts go through my mind?

- ○ A great deal of the time
- ○ A lot of the time
- ○ From time to time, but not too often
- ○ Only occasionally

4 . I can sit at ease and feel relaxed

- ○ Not at all
- ○ Not often
- ○ Usually

- Definitely

5 . I get a sort of frightened feeling like butterflies in my stomach

- Very often
- Quite often
- Occasionally
- Not at all

6 . I feel restless and I have to be on the move

- Very much indeed
- Quite a lot
- Not very much
- Not at all

7 . I get sudden feelings of panic

- Very often indeed
- Quite often
- Not very often
- Not at all

**J. Part J**

1 . I still enjoy the things I used to enjoy

- Hardly at all
- Only a little
- Not quite so much
- Definitely as much

2 . I can laugh and see the funny side of things

- Not at all
- Definitely not so much now
- Not quite so much now
- As much as I always could

3 . I feel cheerful

- Not at all
- Not often
- Sometimes
- Most of the time

4 . I feel as if I am slowed down

- Nearly all the time
- Very often
- Sometimes
- Not at all

5 . I have lost interest in my appearance

- Definitely
- I don’t take as much care as I should
- I may not take quite as much care
- I take just as much care as ever

6 . I look forward with enjoyment to things

- Hardly at all
- Definitely less than I used to
- Rather less than I used to
- As much as I ever did

7 . I can enjoy a good book or radio or TV program

- Very seldom
- Not often
- Sometimes
- Often

**Thank you for completing the paper format of the International Concussion and Head Injury Research Foundation Questionnaire. Please sign the Consent and return all paperwork in the envelope provided.**