

## **PATIENT-HEAD INJURY PARTICIPATION SCALE (P-HIPS)**

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**Reference:** Deb S., Bryant E., Morris P.G., Prior L., Lewis G. & Haque S. (2007) Development and psychometric properties of the Patient-Head Injury Participation Scale (P-HIPS) and the Patient-Head Injury Neurobehavioral Assessment Scale (P-HINAS): patient and family determined outcome scales. *Neuropsychiatric Disease and Treatment*, 3, 3, 373-388.

## **Patient – Head Injury Participation Scale (P-HIPS)**

**Name of the patient:**

**Patient's date of birth:**

**Place where the scale was administered:**

**Name of the person administering the scale:**

**The role of the person administering the scale:**

**Date of completion:**

**The cause of brain injury:**

**The date of brain injury:**

**The initial severity of brain injury (e.g. length of coma, PTA or the lowest GCS score):**

**Current treatments:**

## Patient – Head Injury Participation Scale (P-HIPS)

We are interested in the things that cause you problems in your day-to-day life.

Each question asks whether a particular symptom has been either 'not a problem', or a 'mild', 'moderate' or 'serious' problem for you in your day-to-day life during the past four weeks.

There are 48 questions in total and they all follow the same format.

### EXAMPLE QUESTION

One question asks whether your hearing has caused you problems over the last four weeks.

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Difficulty hearing</b> (loss of hearing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Either the symptom is not present or the symptom is present but does not cause difficulties	The symptom causes some mild problems with day-to-day life, but these are manageable	The symptom causes problems that have a moderate impact upon day-to-day life	The symptom causes problems that have a serious impact upon day-to-day life

## **Therefore for the 'Difficulty hearing' Question:**

If you do not have any difficulty hearing, then tick the 'Not a Problem' box. Or, if you do have difficulty hearing but this does not cause any problems for you (even if it is a bit worse), then tick the 'Not a Problem' box

If it causes some mild problems, but these are manageable, then tick the 'Mild Problem' box

If it causes problems that have a moderate impact upon your life, then tick the 'Moderate Problem' box

If it causes problems that have a serious impact upon your life, then tick the 'Serious Problem' box

**Please tick  one box only**

We have used large text to make the questions easier to read

**PLEASE NOTE THAT QUESTIONS ARE PRINTED ON BOTH SIDES**

## PATIENT – HEAD INJURY NEUROBEHAVIOURAL ASSESSMENT SCALE (P-HINAS)

Please answer all questions

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Temper / Irritable</b> (loss of temper, more aggressive, irritable etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Social behaviour</b> (too loud, causing offence, acting childishly, saying the wrong thing etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lack of motivation</b> (difficulty getting round to doing things, giving up too easily etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Difficulty with feeling tired / Fatigued</b> (feeling tired, drained or exhausted, having less energy etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Difficulty with sleep</b> (sleeping a lot or not sleeping, nightmares etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Feeling scared</b> (frightened, panic attacks etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Paranoia</b> (feeling more suspicious about people etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Feelings of loss</b> (troubled by loss of previous life or how life could have been etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Frustration</b> (because of not being able to do things you would like to etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Worrying about things</b> (feeling anxious or worried etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Crowds</b> (feeling uneasy in large crowds or amongst strangers etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Loss of confidence</b> (less confident in unfamiliar situations or when doing things you used to do etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Depression</b> (feeling down or isolated, suicidal thoughts etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Arguments with close family</b> (arguments with partner, children, parents etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Reduced interest in family</b> (less loving, less caring, less affectionate etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Strain on family</b> (tension, stress or depression amongst family members etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Don't see friends as often as would like</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Lack of good friends</b> (close friends)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lack of understanding from others</b> (people don't understand your situation, people judge or label you etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lack of people to talk to</b> (social interaction, people to confide in etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## **PATIENT – HEAD INJURY COMMUNITY LIVING SCALE (P-HICLS)**

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Difficulty with mobility</b> (getting around places, going up stairs, getting in and out of bed etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lack of independence</b> (rely upon help from others, unable to live by yourself etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sports activities</b> (restrictions in playing sports)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Leisure activities</b> (restrictions in taking part in leisure activities e.g. pub, going out for meals, cinema etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Preparing meals</b> (preparing / cooking meals etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Travel</b> (getting around local area, travelling to shops, visiting friends, going out etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Shopping</b> (buying food, clothes etc. for everyday needs etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Physical self-care</b> (washing, dressing, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Local environment</b> (restriction due to steps or kerbs in local area, lack of ramps, handrails etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Difficulty with balance</b> (loss of balance, standing/sitting upright, walking etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Physical appearance</b> (changes to physical looks due to paralysis or scars, weight change etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Difficulty with eyesight</b> (limited or blurred vision, can't see things properly etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## PATIENT – HEAD INJURY COGNITIVE ASSESSMENT SCALE (P-HICAS)

Please answer all questions

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Group conversations</b> (following conversations when several people speak at the same time etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Difficulty reading</b> (reading letters, bills, newspapers, books etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Difficulty speaking</b> (words come out jumbled, you have to concentrate harder on speech, or people can't understand you properly etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Difficulty with recent memory</b> (short term memory, forgetting things e.g. what day it is, what happened yesterday etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Difficulty with concentration</b> (focusing on reading newspapers, TV, doing tasks, easily distracted etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Difficulty with planning / Organisation</b> (doing things in the right order, allowing enough time etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Difficulty with multi-tasking</b> (doing more than one thing at a time e.g. walking and talking etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dealing with money</b> (paying bills, knowing how much change you should get etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Safety risks</b> (leaving gas/oven on, not safe crossing roads, using electrical goods etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Difficulty hearing</b> (loss of hearing etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## **PATIENT – HEAD INJURY PHYSICAL ASSESSMENT SCALE (P-HIPAS)**

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
<b>Difficulty with headaches</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Difficulty with pain other than headaches</b> (pain in body, legs, arms etc. <u>not</u> headaches)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Difficulty with epilepsy / Fits</b> (blackouts, seizures, absences etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer all questions**

**During the past four weeks, to what extent have the following been a problem for you in your day-to-day life?**

**Difficulty with feeling dizzy /**

**Faint**

(feeling as if head is spinning, vertigo, dizziness, feeling giddy etc.)

**Difficulty with buzzing noise in ear**

(tinnitus etc.)

**Difficulty with sensitivity to noise/light**

(can't tolerate noise or light etc.)

## **ADDITIONAL COMMENTS**

(Feel free to add any additional comments here)

**Thank you for taking the time to complete this questionnaire**

**Please check that you have answered all the questions**