



# Nebraska VR Acquired Brain Injury (ABI) Interview Form

5/2026

Use this form to guide your interview with an individual answering "Yes" or "Not sure" to the ABI pre-screening question on their VR application. Use it anytime an individual indicates they may have experienced an ABI. Do not give it to the individual to complete on their own.

**Step 1.** Share the [What to Expect During Nebraska VR ABI Interview](#) handout with the individual *before* completing the interview.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ VR Specialist: \_\_\_\_\_

Age: \_\_\_\_\_ Veteran:  Yes  No

In competitive, integrated employment:  Yes  No In school or training:  Yes  No

**Step 2.** Prompt the individual to think about all injuries *from external, physical forces* that may have occurred at any age, including those that they don't recall but others may have told them about.

**“In your lifetime (including childhood) have you ever injured your head, face or neck (e.g. from shaking, car or other moving vehicle accident, fall, fight, gunshot, explosion, contact sports or military service, etc.)?” If yes, note the details below:**

Injury #1: \_\_\_\_\_ Age: \_\_\_\_\_ Were you hospitalized or treated in the ER?  Yes  No

Did you lose consciousness?  Yes  No If yes, for how long? \_\_\_\_\_

Were you dazed or did you have a memory gap at the time of injury?  Yes  No If yes, for how long? \_\_\_\_\_

Injury #2: \_\_\_\_\_ Age: \_\_\_\_\_ Were you hospitalized or treated in the ER?  Yes  No

Did you lose consciousness?  Yes  No If yes, for how long? \_\_\_\_\_

Were you dazed or did you have a memory gap at the time of injury?  Yes  No If yes, for how long? \_\_\_\_\_

Injury #3: \_\_\_\_\_ Age: \_\_\_\_\_ Were you hospitalized or treated in the ER?  Yes  No

Did you lose consciousness?  Yes  No If yes, for how long? \_\_\_\_\_

Were you dazed or did you have a memory gap at the time of injury?  Yes  No If yes, for how long? \_\_\_\_\_

**“Was there a time when you received repeated impacts to your head (from shaking, contact sports, military service, interpersonal violence, etc.)?” If yes, note the details below:**

Description: \_\_\_\_\_ From approximately age \_\_\_\_\_ to age \_\_\_\_\_

Were you hospitalized or treated in the ER?  Yes  No

**Step 3.** Prompt the individual to think about all *illnesses or internal, health conditions* that may have occurred at any age, including those that they don't recall but others may have told them about.

**“In your lifetime (including childhood) have you ever experienced an illness or health condition that affected your brain (e.g. cancer, cancer treatment, stroke, meningitis, West Nile, COVID-19, seizure disorder, tumor, near-drowning, poisoning, etc.)?” If yes, note the details below:**

Illness/Condition #1 \_\_\_\_\_ Age: \_\_\_\_\_ Were you hospitalized or treated in the ER?  Yes  No

Did you lose consciousness?  Yes  No If yes, for how long? \_\_\_\_\_

Were you dazed or did you have a memory gap at the time?  Yes  No If yes, for how long? \_\_\_\_\_

Illness/Condition #2: \_\_\_\_\_ Age: \_\_\_\_\_ Were you hospitalized or treated in the ER?  Yes  No

Did you lose consciousness?  Yes  No If yes, for how long? \_\_\_\_\_

Were you dazed or did you have a memory gap at the time?  Yes  No If yes, for how long? \_\_\_\_\_

Illness/Condition #3 \_\_\_\_\_ Age: \_\_\_\_\_ Were you hospitalized or treated in the ER?  Yes  No

Did you lose consciousness?  Yes  No If yes, for how long? \_\_\_\_\_

Were you dazed or did you have a memory gap at the time?  Yes  No If yes, for how long? \_\_\_\_\_

**Step 4.** Complete the Challenges Checklist with the individual to determine the functional impact of reported injuries, repeated impacts, illnesses or health conditions. Ask them to estimate how often the challenge occurs: **Never** = 0% of the time; **Seldom** = 1-20% of the time; **Sometimes** = 21-50% of the time; **Often** = 51-70% of the time; **Always** = 71-100% of the time; **Depends** = If the challenge occurs only in certain situations or environments, add a description.

**“In the time since the injury, illness or condition we talked about, how often...”**

<b>Attention/Concentration</b>	<b>Never</b>	<b>Seldom</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>	<b>Depends</b>
1. Do you have difficulty concentrating on tasks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you get distracted and forget to finish a task?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Memory</b>	<b>Never</b>	<b>Seldom</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>	<b>Depends</b>
3. Do your memory problems interfere with getting things done on time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you struggle to remember what people have said to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you repeat yourself because you don't remember what you told someone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have difficulty keeping track of appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Auditory/Visual Processing</b>	<b>Never</b>	<b>Seldom</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>	<b>Depends</b>
7. Do you have difficulty completing multi-step tasks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have difficulty following verbal (spoken) instructions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have difficulty following written instructions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have difficulty reading maps or understanding diagrams or charts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<b>Language/Communication</b>	<b>Never</b>	<b>Seldom</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>	<b>Depends</b>
11. Do you struggle to complete paperwork or steps to get the services you need?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have difficulty getting people to understand what you're trying to say?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Organization</b>	<b>Never</b>	<b>Seldom</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>	<b>Depends</b>
13. Do you have difficulty staying organized or setting priorities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have difficulty finding your notes or To Do lists?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have difficulty finding documents or other information you need?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you struggle to track completed tasks and those that still need to be done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Executive Function</b>	<b>Never</b>	<b>Seldom</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>	<b>Depends</b>
17. Do you have difficulty estimating or managing time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have difficulty getting ready for appointments or activities on time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you struggle to make decisions, solve problems and have good judgment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Inhibition/Impulsivity	Never	Seldom	Sometimes	Often	Always	Depends
20. Do you say or do things without thinking first about the consequences?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Emotional	Never	Seldom	Sometimes	Often	Always	Depends
21. Do you feel exhausted or overwhelmed by your memory problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you feel stress trying to remember your assignments or plans for the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you sense that your behavior or social skills cause you problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you fear that these problems will keep you from getting the job you want?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you have other concerns that are not listed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments/Observations:

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**Step 5.** Enter all data from this form in QE2. From the Assessment tab on the individual’s case home screen select “ABI Interview Forms”, then click on “+ New ABI Interview Form”. After entering all data, click on “Create ABI Interview Form” to save.

**Step 6.** On the ABI Interview Forms page in QE2, click on the “Strategies” button to download the *ABI Challenges, Accommodations & Compensatory Strategies Summary*. Provide a copy to the individual (print or email). See the Nebraska VR Program Manual, Acquired Brain Injury (ABI) Interview Chapter for additional guidance.