The LENS Inventory

Name___________________________________ Male__ Female__ Date_______________

Date of Birth_________________ Age_______ Diagnosis________________________

Are you able to drive a motor vehicle? (circle one)	Yes	Partially	No
Are you able to work or study?	Yes	Partially	No
Are you able to sustain a close relationship?	Yes	Partially	No

- ***How frequently, in the past month, have you had problems in the following areas? Please pick a number from 0-10. "0" means "not at all" and "10" means "all the time"***
- ***Also, if one or both of your parents had this, or a similar problem, place a P in the column headed by "Parents?"***
- ***And, if the problem came on suddenly, put an S in the column headed by "Suddenly?"***

Sensory	**Frequency**	**Parents?**	**Suddenly?**
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 irritability	________	________	________
Problems with suicidal thoughts or actions	________	________	________
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	________	________	________
Knee pain	________	________	________
Joint pain	________	________	________
All-over pain	________	________	________
Other pain______________________________(specify)	________	________	________

(over)

Clarity	Frequency	Parents?	Suddenly?
Feel “foggy” and have problems with clarity	________	________	_______
Problems following conversations (with good hearing)	________	________	_______
Problems with confusion	________	________	_______
Problems following what you are reading	________	________	_______
Problems with concentration	________	________	_______
Problems with attention	________	________	_______
Problems with sequencing	________	________	_______
Problems with prioritizing	________	________	_______
Problems not finishing what you start	________	________	_______
Problems with getting lost in daydreaming	________	_______	_______
Energy			
Problems with stamina	________	________	_______
Fatigue during the day	________	________	_______
Trouble sleeping at night	________	________	_______
Problems awakening at night	________	________	_______
Problems falling asleep again	________	________	_______
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	________	________	_______
Other Problems			
Problems with nausea	________	________	_______
Skin problems	________	________	_______
Problems with speech or articulation	________	________	_______
Dizziness	________	________	_______
Noise in ears (Tinnitus)	________	________	_______
Any other problem?_______________________(specify)	________	________	_______