NEUROLOGICAL ASSESSMENT FORM

Name of Patient_____ SEX_____ Age_____

Initial Diagnosis_____

Examining MD:_____

DETAILS / PARTICULARS / QUESTIONS	RESPONSE	
□ Are you left or right handed?	Right	Left
□ Have you ever had a head injury?	YES	NO
□ Have you ever lost consciousness?	YES	NO
□ Do you currently experience of have a past history of dizziness?	YES	NO
□ Do you have any ringing in the ears?	YES	NO
□ Do you experience nausea?	YES	NO
□ Do you find that your balance is getting worse?	YES	NO
□ Do you have difficulties going down stairs?	YES	NO
□ Do you have a hard time with math problems or computing numbers?	YES	NO
□ Do you find yourself searching for words frequently when you speak?	YES	NO
□ Have you noticed your ability to concentrate is getting worse?	YES	NO
□ Do you fatigue after reading?	YES	NO
□ Do you get lost often or have a hard time with directions?	YES	NO
□ Does loud or scattered noise bother you?	YES	NO
□ Do quick flashes of light on TV or movies bother you?	YES	NO
□ Do you feel like you need to wear sunglasses outside?	YES	NO
□ Has you handwriting changed in recent years?	YES	NO
□ Do you have a hard time swallowing?	YES	NO
□ Do you gag easily?	YES	NO
□ Do you experience blurriness in your vision?	YES	NO

□ Do you ever have double-vision?	YES	NO
□ Do you have any difficulty with smell?	YES	NO
□ Do you smell foul things that are not present?	YES	NO
□ Do you have any difficulty with taste?	YES	NO
□ Do you taste things differently than what you are eating?	YES	NO
□ Have you noticed clumsiness in hand coordination?	YES	NO
□ Do you have difficulty with short-term memory?	YES	NO
□ Have you been told or noticed any memory loss of past events?	YES	NO
□ Have you noticed uneven sweating or temperature on one side of our body?	YES	NO
□ Do you have any tightness, feeling of weakness or instability in your back or neck?	YES	NO
□ Do you have any tightness, or feelings of weakness in your hands or legs?	YES	NO
□ Do you ever have any numbness or tingling in your hands, legs or face?	YES	NO
□ Have you noticed any twitches or cramping in your legs or hands?	YES	NO
□ Do you have any difficulty with falling or staying asleep?	YES	NO
□ Do you get motion sickness easily (car sick or sea sick)?	YES	NO
□ Do you ever experience flashes of light in your visual field?	YES	NO
□ Do you ever see floating objects in your visual field?	YES	NO
□ Do you ever experience dry eyes or mouth?	YES	NO
□ Do you ever experience increase tearing or salivation	YES	NO
□ Do you feel pressure in your ear?	YES	NO
□ Do you suffer from frequent bloating or gas?	YES	NO
□ Do you feel that you do not digest your food well?	YES	NO
□ Do you ever have slurred speech?	YES	NO
□ Do you ever have dropping of your eyelids?	YES	NO
□ Do you ever notice fatigue of your facial muscles?	YES	NO

□ Do you ever have jaw tightness or diagnosed with TMJ dysfunction?	YES	NO
□ Do you ever notice increased heart rate or pulse during the day?	YES	NO
□ Have you ever experienced or been diagnosed of arrhythmia (fluctuating heart rate)?	YES	NO
□ Have you ever been diagnosed or experienced tachycardia (fast heart rate)?	YES	NO
□ Does driving cause you fatigue, headaches or any other symptoms?	YES	NO
□ Does working on a computer cause you fatigue, headaches or other symptoms?	YES	NO
□ Do you ever have increased/decreased urination (normal is 6-8 a day) or wet the bed?	YES	NO
□ Do you have increased/decreased bowel (normal is 3 a day) movements?	YES	NO
□ Have you lost your interest in hobbies and functions that you used to enjoy?	YES	NO
□ Do you have a hard time motivating yourself to engage in activities?	YES	NO
□ Do you ever have fluttering of the eye or noticed you are blinking frequently?	YES	NO
□ Do you have difficulty distinguishing right and left?	YES	NO
□ Did you find this questionnaire difficult?	YES	NO

IMPRESSIONS / COMMENTS:

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Name and Signature of MD or ROD

Date: