

NEUROLOGICAL ASSESSMENT FORM

NAME: _____ DATE: _____

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|---|-------|------|
| 1. Are you left or right handed?..... | Right | Left |
| 2. Have you had a head injury?..... | Yes | No |
| 3. Do you currently experience or have a past history of vertigo or balance disorders?..... | Yes | No |
| 4. Do you have any ringing or pressure in your ears? | Yes | No |
| 5. Do you experience nausea? | Yes | No |
| 6. Do you find that your balance is getting worse? | Yes | No |
| 7. Do you have difficulties walking down stairs?..... | Yes | No |
| 8. Do you find yourself searching for words frequently when you speak?..... | Yes | No |
| 9. Have you noticed your ability to concentrate is getting worse? | Yes | No |
| 10. Do you get lost often or have a hard time with directions?..... | Yes | No |
| 11. Do quick flashes of light on TV or loud noises bother you? | Yes | No |
| 12. Do you feel like you need to wear sunglasses outside?..... | Yes | No |
| 13. Has your handwriting changed in recent years? | Yes | No |
| 14. Do you have a hard time swallowing? | Yes | No |
| 15. Do to gag easily?..... | Yes | No |
| 16. Do you experience blurriness in you vision or have double vision? | Yes | No |
| o CIRCLE ALL THAT APPLY: Blurriness, Double Vision | | |
| 17. Do you have any changes in smell or smell foul things that are not present?..... | Yes | No |
| 18. Do you have any difficulty with taste or taste things differently than what you are eating? | Yes | No |
| 19. Have you noticed clumsiness in hand coordination? | Yes | No |
| o Which hand? CIRCLE: Right, Left | | |
| 20. Do you have difficulty with short-term memory? | Yes | No |
| 21. Have you been told you have or noticed any memory loss of past events?..... | Yes | No |
| 22. Have you noticed uneven sweating or temperature on one side of your body?..... | Yes | No |
| 23. Do you have any tightness, weakness or instability in your back or neck?..... | Yes | No |
| o CIRCLE ALL THAT APPLY: Back, Neck | | |
| 24. Do you have tightness or feelings of weakness in you arms/hands or legs/feet?..... | Yes | No |
| o CIRCLE ALL THAT APPLY: Arms/hands, Legs/feet | | |
| 25. Do you ever have any numbness or tingling in your arms/hands, legs/feet or face?..... | Yes | No |
| o CIRCLE ALL THAT APPLY: Arms/hands, Legs/feet, Face | | |
| 26. Do you have any difficulty with falling asleep or staying asleep?..... | Yes | No |
| o CIRCLE ALL THAT APPLY: Falling asleep, Staying asleep | | |
| 27. Do you get motion sickness easily (car sick or sea sick)? | Yes | No |
| 28. Do you ever experience flashes of light in you visual fields?..... | Yes | No |
| 29. Do you ever experience dry eyes or mouth?..... | Yes | No |
| o CIRCLE ALL THAT APPLY: Eyes, Mouth | | |
| 30. Do you ever experience increased tearing or salivation?..... | Yes | No |
| o CIRCLE ALL THAT APPLY: Tearing, Salivation | | |
| 31. Do you ever have slurred speech?..... | Yes | No |
| 32. Have you noticed any drooping of your eyelids or facial muscles?..... | Yes | No |
| o CIRCLE ALL THAT APPLY: Eyelids, Facial Muscles | | |
| 33. Do you ever notice increased heart rate or pulse during the day? | Yes | No |
| 34. Have you ever experienced or been diagnosed with arrhythmia (fluctuating heart rate)? | Yes | No |
| 35. Do you experience Deja Vu? | Yes | No |
| 36. Does driving cause you fatigue, headaches or any other symptoms?..... | Yes | No |
| o CIRCLE ALL THAT APPLY: Fatigue, Headaches, Other Symptoms | | |
| 37. Does working on a computer cause you fatigue, headaches or other symptoms? | Yes | No |
| o CIRCLE ALL THAT APPLY: Fatigue, Headaches, Other Symptoms | | |
| 38. Have you lost your interest in hobbies and functions you used to enjoy? | Yes | No |
| 39. Do you have a hard time motivating yourself to engage in activities?..... | Yes | No |
| 40. Do you ever have a fluttering of the eye or noticed you are blinking frequently? | Yes | No |
| 41. Do you have difficulty distinguishing right and left?..... | Yes | No |

Patient Signature: _____ Date: _____