NEUROLOGICAL ASSESSMENT FORM

NAME: _____ **DATE:**_____

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

Patient Signature:_____ **Date:** _____