NEUROLOGICAL ASSESSMENT FORM

NAME: _____ **DATE:**_____

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
    - 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
    - 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
    - CIRCLE ALL THAT APPLY: Back, Neck
24. 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
25. 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
26. Do you have any difficulty with falling asleep or staying asleep?…… Yes No
    - 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
    - CIRCLE ALL THAT APPLY: Eyes, Mouth
30. Do you ever experience increased tearing or salivation?…… Yes No
    - 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
    - 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
    - CIRCLE ALL THAT APPLY: Fatigue, Headaches, Other Symptoms
37. Does working on a computer cause you fatigue, headaches or other symptoms? …… Yes No
    - 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:** _____