NEUROLOGICAL ASSESSMENT FORM

NAME_____ **SEX**_____ **DATE**_____

Purpose of appointment_____

- ☐ 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
- ☐ Do you experience De Ja vu? 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

PLEASE COMMENT OR ELABORATE ON ANY QUESTIONS BELOW

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