Neuro Check Form

Patient Information:

Name: ______________________

Date of Birth: ______________________

Medical Record Number: ______________________

Date/Time of Assessment: ______________________

Vital Signs:

Blood Pressure: ______________________

Heart Rate: ______________________

Respiratory Rate: ______________________

Temperature: ______________________

Level of Consciousness:

Glasgow Coma Scale (GCS) Score: ___________

Eye Opening (E): ___________

Verbal Response (V): ___________

Motor Response (M): ___________

Mental Status:

Orientation to Person, Place, Time: ____

Response to Verbal Stimuli: ____

Response to Painful Stimuli: ____

Motor Function:

Muscle Strength (Scale from 0 to 5):

- Upper Extremities (UE): ______________________
- Lower Extremities (LE): ______________________

Coordination Exam:

- Rapid Alternating Movements: ____
- Finger-to-Nose Test: ____

Sensory Examination:

Response to Light Touch:

- Bilateral assessment: ____

Response to Pain:

- Bilateral assessment: ____

Cranial Nerves:

I: Olfactory (Sense of Smell): ____

II: Optic (Visual Acuity): ____

III: Oculomotor: ____

IV: Trochlear: ____

V: Trigeminal (Sensory and Motor Functions): ____

VI: Abducens: ____

VII: Facial: ____

VIII: Vestibulocochlear (Hearing and Balance): ____

IX: Glossopharyngeal: ____

X: Vagus: ____

XI: Accessory: ____

XII: Hypoglossal: ____

Reflexes:

Deep Tendon Reflexes (Use a scale, e.g., 0 to 4):

- Biceps: ______________________
- Triceps: ______________________
- Brachioradialis: ______________________
- Patellar: ______________________
- Achilles: ______________________

Bilateral Plantar Reflex (Upgoing/Downgoing): ______________________

Other Observations:

- **Pupillary Response:**
  - Size, Equality, Reactivity to Light: ____
- **Any Abnormal Movements or Posturing:**
- **Any Signs of Focal Cortical Functioning:**