

Neurological Assessment

Patient Name:		Date:	
DoB:	Age:	Sex:	Gender:

Insurance:

CC & Significant History:

Key Consideration

Headache Dizziness/Vertigo Tremors Incoordination Difficulty Swallowing
 Head Injury Seizures Weakness Numbness/Tingling Difficulty Speaking
 Significant Past History Environmental Hazards Other:
 Refer to secondary consultation:
 Refer to diagnostic imaging:

	Mental Status	<input type="checkbox"/> WNL (Within Normal Limits)
Development	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Behavior	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Confusion <input type="checkbox"/> Speech	
Orientation	<input type="checkbox"/> Time <input type="checkbox"/> Person <input type="checkbox"/> Place & Situation	
Memory/Concentration		
<input type="checkbox"/> Name president/recent newsworthy events	<input type="checkbox"/> 3 word or place recall at 0 and 5 minutes	
<input type="checkbox"/> (100) - (7) up to five times (93, 86,79...)	<input type="checkbox"/> Spell word backwards	
<input type="checkbox"/> Draw a clock (make the time 12:30)	<input type="checkbox"/> Draw overlapping pentagons	
Comments		

For the remaining sections, N = Normal, A = Abnormal. If Abnormal, Describe in Comments Section

	Reflexes	<input type="checkbox"/> WNL (Within Normal Limits)
DTR (Rate from 0-4)	Right Left	Pathologic Right Left
Biceps (C5)	<input type="text"/> <input type="text"/>	Babinski <input type="checkbox"/> N <input type="checkbox"/> A <input type="checkbox"/> N <input type="checkbox"/> A
Brachioradialis (C6)	<input type="text"/> <input type="text"/>	Abdominal <input type="checkbox"/> N <input type="checkbox"/> A <input type="checkbox"/> N <input type="checkbox"/> A
Triceps (C7)	<input type="text"/> <input type="text"/>	Hoffman's <input type="checkbox"/> N <input type="checkbox"/> A <input type="checkbox"/> N <input type="checkbox"/> A
Patella (L4)	<input type="text"/> <input type="text"/>	
Hamstring (L5)	<input type="text"/> <input type="text"/>	
Achilles (S1)	<input type="text"/> <input type="text"/>	
Comments		

Motor Function		<input type="checkbox"/> WNL (Within Normal Limits)		Comments
Motor (Rate from 0-5)	Right	Left		
Deltoid (C5, C6) (axillary)	<input type="text"/>	<input type="text"/>		
Brachioradialis (C5, C6) (radial)	<input type="text"/>	<input type="text"/>		
Biceps (C5, C6) (musculocut.)	<input type="text"/>	<input type="text"/>		
Triceps (C6, C7, C8, T1) (radial)	<input type="text"/>	<input type="text"/>		
Wrist flexors (C6, C7) (med /ulnar)	<input type="text"/>	<input type="text"/>		
Wrist extensors (C6, C7, C8) (rad.)	<input type="text"/>	<input type="text"/>		
Interossei (C7, C8, T1) (ulnar)	<input type="text"/>	<input type="text"/>		
Tib. anterior (L4, L5) (deep per.)	<input type="text"/>	<input type="text"/>		
Extensor hallucis longus (L4, L5, S1) (deep peroneal)	<input type="text"/>	<input type="text"/>		
Fibularis (peroneus) longus (L5, S1) (superficial peroneal)	<input type="text"/>	<input type="text"/>		

Cranial Nerve				<input type="checkbox"/> WNL (Within Normal Limits)				
I - Olfactory		Right	Left	VII - Facial		Right	Left	
Scent #1	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	Facial expressions	<input type="checkbox"/> N	<input type="checkbox"/> A	
Scent #2	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	Facial expression #2	<input type="checkbox"/> N	<input type="checkbox"/> A	
II - Optic		Right	Left	VIII - Vestibulocochlear		Right	Left	
Visual acuity	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	Rhomberg's test	<input type="checkbox"/> N	<input type="checkbox"/> A	
Visual fields	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	Auditory acuity	<input type="checkbox"/> N	<input type="checkbox"/> A	
Funduscopy exam	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	Weber	<input type="checkbox"/> N	<input type="checkbox"/> A	
III, IV, VI		Right	Left	IX, X		Right	Left	
"H pattern	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	Gag reflex	<input type="checkbox"/> N	<input type="checkbox"/> A	
Convergence	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	Elevation of palate	<input type="checkbox"/> N	<input type="checkbox"/> A	
Nystagmus	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	XI - Spinal Accessory		Right	Left
Consensual light reflex	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	Trapezius muscle test	<input type="checkbox"/> N	<input type="checkbox"/> A	
V - Trigeminal		Right	Left	XII - Hypoglossal		Right	Left	
Lateral jaw deviation	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	Stick out tongue	<input type="checkbox"/> N	<input type="checkbox"/> A	
Masseter contraction	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A				
Face sensation	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A				
Corneal touch reflex	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A				

Comments

Cerebellar				<input type="checkbox"/> WNL (Within Normal Limits)			
	Right	Left		Right	Left		
Rapid finger movement	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	Heel down shin	<input type="checkbox"/> N	<input type="checkbox"/> A
Rapid pro/supination	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	Holme's rebound sign	<input type="checkbox"/> N	<input type="checkbox"/> A
Finger-to-nose/finger	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A	Gait/heel-toe walk	<input type="checkbox"/> N	<input type="checkbox"/> A

Comments

Nerve Tension

WNL (Within Normal Limits)

	Right		Left	
Straight Leg Raise	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Maximal SLR	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Bragard's	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Femoral nerve traction	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A

	Right		Left	
Median nerve traction	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Radial nerve traction	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Ulnar nerve traction	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Tinel's	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A

Comments

Sensory

WNL (Within Normal Limits)

	Right		Left	
Light touch	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Vibration	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Stereognosis	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Graphesthesia	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
2-point discrim	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A

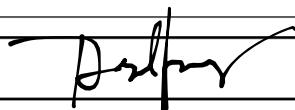
	Right		Left	
Position sense	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Proprioception	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Romberg	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Sharp/Dull	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A
Hot/Cold	<input type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> A

Comments

Differential Diagnosis

Additional Comments

Signature:



Date: