Neurological Exam

Patient Information	
Name:	
Date of Birth:	Patient ID:
Date of Assessment:	Referring Physician:
Patient Preparation	
Consent Obtained: ☐ Yes No	**Pre-Assessment Instructions Provided:** ☐ Yes No
Mental Status Examination	
Orientation: ☐ Time Place Person	
Memory: ☐ Short-Term Long-Term	**Attention Span:** ☐ Normal Impaired
Language Abilities: ☐ Speech Comprehension Reading Writing	
Observations / Concerns:	
Cranial Nerves Examination	
1. Olfactory (I): Smell Identification ☐ Normal Impaired	**2. Optic (II):** Visual Acuity ☐ Normal Impaired
3. Oculomotor (III), Trochlear (IV), Abducens (VI): Pupil Response, Eye Movement ☐ Normal Impaired	

4. Trigeminal (V): Facial Sensation, Jaw Movement ☐ Normal Impaired	**7. Glossopharyngeal (IX), Vagus (X):** Swallowing, Gag Reflex ☐ Normal Impaired
5. Facial (VII): Facial Symmetry, Taste ☐ Normal Impaired	**8. Accessory (XI):** Shoulder Shrug, Head Turn ☐ Normal Impaired
6. Vestibulocochlear (VIII): Hearing ☐ Normal Impaired	**9. Hypoglossal (XII):** Tongue Movement ☐ Normal Impaired
Observations / Concerns:	
Motor System Evaluation	
Muscle Strength: ☐ Upper Limbs Lower Limbs	**Muscle Tone:** ☐ Normal Increased Decreased
Observations / Concerns:	
Sensory System Assessment	
Light Touch: ☐ Normal Impaired	**Pain:** ☐ Normal Impaired
Temperature: ☐ Normal Impaired	**Vibration:** ☐ Normal Impaired
Proprioception: ☐ Normal Impaired	

Observations / Concerns:

Reflexes Testing

Deep Tendon Reflexes:

- [ ] Biceps Triceps Brachioradialis Patellar Achilles

Scale: 0 (Absent) - 4 (Hyperactive)

- [ ] 0 1 2 3 4

Pathological Reflexes:

Babinski

- [ ] Absent Present

Observations / Concerns:

Coordination and Gait Analysis

Coordination Tests:

- [ ] Finger-to-Nose Heel-to-Shin

Gait:

- [ ] Normal Ataxic Spastic Other:

Observations / Concerns:

Final Assessment and Plan

Overall Neurological Status:

Specific Concerns / Findings:

Recommendations:

☐ Further Testing   Specialist Referral   Treatment Plan

Follow-Up Appointments:

Assessor's Signature:

Date:

Patient Consent for Assessment and Use of Data

I consent to the neurological examination and understand the confidentiality and limits thereof.

Patient's / Guardian's Signature:

Date: