NEUROLOGICAL ASSESSMENT FORM

Patient 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 the 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 have difficulty with math problems, or remembering numbers?	YES	NO
9.	Do you find yourself searching for words frequently when you speak?	YES	NO
10.	Have you noticed your ability to concentrate is getting worse?	YES	NO
11.	Do you get lost often or have a hard time with directions?	YES	NO
12.	Do quick flashes of light on TV or loud noises bother you?	YES	NO
13.	Do you feel like you need to wear sunglasses outside?	YES	NO
14.	Has your handwriting changed in recent years?	YES	NO
15.	Do you have a hard time swallowing?	YES	NO
16.	Do you gag easily?	YES	NO
17.	Do you experience *blurriness in your vision* or *double vision*? **← (circle)**	YES	NO
18.	Do you have any changes in smell or smell foul things that are not present?	YES	NO
19.	Do you have difficulty with taste or taste things differently than what you are eating?	YES	NO
20.	Noticed clumsiness in hand coordination? Which Hand? **Right / Left ← (circle)**	YES	NO
21.	Do you have difficulty with short-term memory?	YES	NO
22.	Have you been told or noticed any memory loss of past events?	YES	NO
23.	Noticed uneven sweating or temperature on one side of your body?	YES	NO
24.	Do you have any *tightness, weakness,* or *instability* in your *back* or *neck*? **← (circle)**	YES	NO
25.	Do you have any *tightness,* or *feelings of weakness* in your *hands* or *legs*? **← (circle)**	YES	NO
26.	Do you ever have any *numbness* or *tingling* in your *hands, legs,* or *face*? **← (circle)**	YES	NO
27.	Do you have any difficulty with falling asleep or staying asleep?	YES	NO
28.	Do you get motion sickness easily (car sick or sea sick)?	YES	NO
29.	Do you ever experience flashes of light in your visual field?	YES	NO
30.	Do you ever experience dry *eyes* or *mouth*? **←(circle)**	YES	NO

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31. Do you ever experience increase *tearing* or *salivation*? **←(circle)** YES NO
32. Do you ever have slurred speech? YES NO
33. Noticed any drooping of your *eyelids* or *facial muscles*? **←(circle)** YES NO
34. Do you ever notice increased heart rate (tachycardia) or pulse during the day? YES NO
35. Have you ever experienced or been diagnosed with arrhythmia (fluctuating heart rate)? YES NO
36. Do you experience Déjà vu? YES NO
37. Does driving cause you *fatigue, headaches,* or *any other symptoms*? **←(circle)** YES NO
38. Does working on a computer cause you fatigue, headaches, or other symptoms? YES NO
39. Have you lost your interest in hobbies and functions that you used to enjoy? YES NO
40. Do you have a hard time motivating yourself to engage in activities? YES NO
41. Do you ever have fluttering of the eye or noticed you are blinking frequently? YES NO
42. Do you have difficulty distinguishing right and left? YES NO

Is there anything else that would be helpful to know_____