



NeuroMetabolic ASSOCIATES

NEUROLOGICAL ASSESSMENT FORM

NAME: _____

DATE: _____

- | | Right | Left |
|--|-------|------|
| <input type="radio"/> Are you left or right handed?----- | Right | Left |
| <input type="radio"/> Have you had a head injury----- | YES | NO |
| <input type="radio"/> Do you currently experience or have past history of vertigo or balance disorders----- | Y | N |
| <input type="radio"/> Do you have any ringing or pressure in the ears----- | Y | N |
| <input type="radio"/> Do you experience nausea----- | Y | N |
| <input type="radio"/> Do you find that your balance is getting worse----- | Y | N |
| <input type="radio"/> Do you have difficulties walking down stairs----- | Y | N |
| <input type="radio"/> Do you have difficulty with math problem, or remembering numbers----- | Y | N |
| <input type="radio"/> Do you find yourself searching for words frequently when you speak----- | Y | N |
| <input type="radio"/> Have you noticed your ability to concentrate is getting worse----- | Y | N |
| <input type="radio"/> Do you get lost often or have a hard time with directions----- | Y | N |
| <input type="radio"/> Do quick flashes of light on TV or loud noises bother you----- | Y | N |
| <input type="radio"/> Do you feel like you need to wear sunglasses outside----- | Y | N |
| <input type="radio"/> Has your handwriting changed in recent years----- | Y | N |
| <input type="radio"/> Do you have a hard time swallowing----- | Y | N |
| <input type="radio"/> Do you gag easily----- | Y | N |
| <input type="radio"/> Do you experience blurriness in your vision or double vision----- | Y | N |
| <input type="radio"/> Do you have any changes in smell or smell foul things that are not present----- | Y | N |
| <input type="radio"/> Do you have any difficulty with taste or taste things differently than what you are eating | Y | N |
| <input type="radio"/> Noticed clumsiness in hand coordination. Which hand Right/Left (CIRCLE) ----- | Y | N |
| <input type="radio"/> Do you have any difficulty with short-term memory----- | Y | N |
| <input type="radio"/> Have you been told or notice d any memory loss of past events----- | Y | N |
| <input type="radio"/> Noticed uneven sweating or temperature on one side of your body----- | Y | N |
| <input type="radio"/> Do you have any tightness, weakness or instability in your back/neck (CIRCLE) ----- | Y | N |
| <input type="radio"/> Do you have tightness or feelings of weakness in your hands/legs (CIRCLE) ----- | Y | N |
| <input type="radio"/> Do you ever have any numbness or tingling in your hands, legs, or face (CIRCLE) ----- | Y | N |
| <input type="radio"/> Do you have any difficulty with falling asleep or staying asleep----- | Y | N |
| <input type="radio"/> Do you get motion sickness easily (car sick or sea sick)----- | Y | N |
| <input type="radio"/> Do you ever experience flashes of light in your visual field----- | Y | N |
| <input type="radio"/> Do you ever experience dry eyes or moth----- | Y | N |
| <input type="radio"/> Do you ever experience increased tearing or salivation----- | Y | N |
| <input type="radio"/> Do you ever have slurred speech----- | Y | N |
| <input type="radio"/> Noticed any dropping of your eyelids or facial muscles----- | Y | N |
| <input type="radio"/> Do you ever notice increased heart rate (tachycardia) or pulse during the day----- | Y | N |
| <input type="radio"/> Have you ever experienced or been diagnosed with arrhythmia (fluctuation heart rate)-- | Y | N |
| <input type="radio"/> Do you experience Déjà vu----- | Y | N |
| <input type="radio"/> Does driving cause you fatigue, headaches, or any other symptoms----- | Y | N |
| <input type="radio"/> Does working on a computer cause you fatigue, headaches, or other symptoms----- | Y | N |
| <input type="radio"/> Have you lost your interest in hobbies and function that you uses to enjoy----- | Y | N |
| <input type="radio"/> Do you have a hard time motivating yourself to engage in activities----- | Y | N |
| <input type="radio"/> Do you ever hav3e fluttering of the eye or noticed you are blinking frequently----- | Y | N |
| <input type="radio"/> Do you have difficulty distinguishing right and left----- | Y | N |

Patient Signature: _____

Date: _____