THE NeuroMetabolic INSTITUTE

NEUROLOGICAL ASSESSMENT FORM

NAME: _____ DATE: _____

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