Boca Health Care Center

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

Patient Signature: _____ Date: _____