

ATIYEH CHIROPRACTIC

NEUROLOGICAL ASSESSMENT FORM

Name: _____

Date: _____

	<u>Right</u>	<u>Left</u>
Are you left or right handed? _____	Yes	No
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? _____	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 or past events? _____	Yes	No
Noticed uneven sweating or temperature on one side of your body? _____	Yes	No
Do you have 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 any other symptoms? _____	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