

NEUROLOGICAL ASSESSMENT FORM

NAME: _____ SEX: _____ DATE: _____

Purpose of appointment _____

Decreased function of the C.N.S (Brain and Spinal Cord) manifests signs and symptoms of abnormal motor, sensory, mental and body contour called subluxation.

- | | Right | Left |
|--|-------|------|
| <input type="checkbox"/> Are you left or right handed? _____ | YES | NO |
| <input type="checkbox"/> Have you had a head injury? _____ | YES | NO |
| <input type="checkbox"/> Have you ever lost consciousness? _____ | YES | NO |
| <input type="checkbox"/> Do you currently experience or have a past history of vertigo or balance disorders? _____ | YES | NO |
| <input type="checkbox"/> Do you have any ringing or pressure in the ears? _____ | YES | NO |
| <input type="checkbox"/> Do you experience nausea? _____ | YES | NO |
| <input type="checkbox"/> Do you find that your balance is getting worse? _____ | YES | NO |
| <input type="checkbox"/> Do you have difficulties walking down stairs? _____ | YES | NO |
| <input type="checkbox"/> Do you have difficulty with math problems or computing numbers? _____ | YES | NO |
| <input type="checkbox"/> Do you find yourself searching for words frequently when you speak? _____ | YES | NO |
| <input type="checkbox"/> Have you noticed your ability to concentrate is getting worse? _____ | YES | NO |
| <input type="checkbox"/> Do you fatigue after reading? _____ | YES | NO |
| <input type="checkbox"/> Do you get lost often or have a hard time with directions? _____ | YES | NO |
| <input type="checkbox"/> Does loud or scattered noise bother you? _____ | YES | NO |
| <input type="checkbox"/> Do quick flashes of light on TV or movies bother you? _____ | YES | NO |
| <input type="checkbox"/> Do you feel like you need to wear sunglasses outside? _____ | YES | NO |
| <input type="checkbox"/> Has your handwriting changed in recent years? _____ | YES | NO |
| <input type="checkbox"/> Do you have a hard time swallowing? _____ | YES | NO |
| <input type="checkbox"/> Do you gag easily? _____ | YES | NO |
| <input type="checkbox"/> Do you experience blurriness in your vision? _____ | YES | NO |
| <input type="checkbox"/> Do you ever have double-vision? _____ | YES | NO |
| <input type="checkbox"/> Do you have any changes in smell? _____ | YES | NO |
| <input type="checkbox"/> Do you smell foul things that are not present? _____ | YES | NO |
| <input type="checkbox"/> Do you have any difficulty with taste? _____ | YES | NO |
| <input type="checkbox"/> Do you taste things differently than what you are eating? _____ | YES | NO |
| <input type="checkbox"/> Have you noticed clumsiness in hand coordination? _____ | YES | NO |
| <input type="checkbox"/> Do you have difficulty with short-term memory? _____ | YES | NO |
| <input type="checkbox"/> Have you been told or noticed any memory loss of past events? _____ | YES | NO |
| <input type="checkbox"/> Have you noticed uneven sweating or temperature on one side of your body? _____ | YES | NO |
| <input type="checkbox"/> Do you have any tightness, feeling of weakness or instability in your back or neck? _____ | YES | NO |
| <input type="checkbox"/> Do you have tightness, or feelings of weakness in your hands or legs? _____ | YES | NO |
| <input type="checkbox"/> Do you ever have any numbness or tingling in your hands, legs, or face? _____ | YES | NO |
| <input type="checkbox"/> Have you noticed any twitches or cramping in your hands, legs, or face? _____ | YES | NO |
| <input type="checkbox"/> Do you have any difficulty with falling asleep or staying asleep? _____ | YES | NO |
| <input type="checkbox"/> Do you get motion sickness easily (car sick or sea sick)? _____ | YES | NO |

Please turn over to complete questionnaire

