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
☐ Are you left or right handed?		
☐ Have you had a head injury?	YES	NO
☐ Have you ever lost consciousness?	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 computing 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 fatigue after reading?	YES	NO
☐ Do you get lost often or have a hard time with directions?	YES	NO
☐ Does loud or scattered noise bother you?	YES	NO
☐ Do quick flashes of light on TV or movies 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?	YES	NO
☐ Do you ever have double-vision?	YES	NO
☐ Do you have any changes in smell?	YES	NO
☐ Do you smell foul things that are not present?	YES	NO
☐ Do you have any difficulty with taste?	YES	NO
☐ Do you taste things differently than what you are eating?	YES	NO
☐ Have you noticed clumsiness in hand coordination?	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
☐ Have you noticed uneven sweating or temperature on one side of your body?	YES	NO
☐ Do you have any tightness, feeling of weakness or instability in your back or neck?	YES	NO
☐ Do you have tightness, or feelings of weakness in your hands or legs?	YES	NO
☐ Do you ever have any numbess or tingling in your hands, legs, or face?	YES	NO
☐ Have you noticed any twitches or cramping in your hands, legs, or face?	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

Please turn over to complete questionnaire

- ☐ Do you ever experience flashes of light in your visual field? YES NO
- ☐ Do you ever see floating objects in your visual field? YES NO
- ☐ Do you ever experience dry eyes or mouth? YES NO
- ☐ Do you ever experience increase tearing or salivation? YES NO
- ☐ Do you suffer from frequent bloating or gas? YES NO
- ☐ Do you feel that you do not digest your food well? YES NO
- ☐ Do you ever have slurred speech? YES NO
- ☐ Do you ever have drooping of your eyelids? YES NO
- ☐ Do you ever notice fatigue of your facial muscles? YES NO
- ☐ Do you ever have jaw tightness or diagnosed with TMJ dysfunctions? YES NO
- ☐ Do you ever notice increased heart rate or pulse during the day? YES NO
- ☐ Have you ever experienced or been diagnosed with arrhythmia (fluctuating heart rate)? YES NO
- ☐ Have you ever been diagnosed or experienced tachycardia (fast heart rate)? YES NO
- ☐ Do you experience Deja 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
- ☐ Do you ever have increased/decreased urination (normal is 6-8 a day) or wet the bed? YES NO
- ☐ Do you have increased/decreased bowel (normal is 3 a day) movements? 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
- ☐ Did you find this questionnaire difficult? YES NO

PLEASE COMMENT OR ELABORATE ON ANY QUESTIONS BELOW

Print Name: _____ Sign Name: _____ Date: _____