Neurological Assessment Form

Lynch Chiropractic and Chronic Pain Solutions

Name: Age: 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.

Are you left or right handed? _____ Right Left

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 have 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 numbness 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

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 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
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:_____