

Neuro Check Form

PATIENT INFORMATION

Full name: _____ Date of birth: _____ dd / mm / yyyy
Medical record number: _____ Date of assessment: _____ dd / mm / yyyy
Time of assessment: _____

VITAL SIGNS

Blood pressure: _____ Heart rate: _____
Respiratory rate: _____ Temperature: _____
Other relevant vital signs:

LEVEL OF CONSCIOUSNESS

Glasgow Coma Scale (GCS)

Eye opening: _____ Verbal response: _____
Motor response: _____ Score: _____

National Institutes of Health Stroke Scale (NIHSS)

Balance: _____ Eyes: _____
Face: _____ Arm: _____
Speech test: _____

Findings:

Mini-mental Status Exam (MMSE)

Score: _____

Notes:

CRANIAL NERVES

I. Olfactory (sense of smell):

II. Optic (visual acuity):

III. Oculomotor:

IV. Trochlear:

V. Trigeminal (sensory and motor functions):

VI. Abducens:

VII. Facial:

VIII. Vestibulocochlear (hearing and balance):

IX. Glossopharyngeal:

X. Vagus:

XI. Spinal accessory:

XII. Hypoglossal:

Additional notes:

SENSORY EXAMINATION

Response to light touch:

Response to pain:

Additional notes:

MOTOR STRENGTH

Hand grasps:

Upper extremity strength:

Lower extremity strength:

Additional notes:

CEREBELLAR FUNCTION

Gait and balance:

Pronator drift:

Finger-to-nose test:

Rapid alternating action:

Heel-to-shin test:

Additional notes:

REFLEXES

Deep tendon reflexes **Recommendation: Use a scale, e.g. 0 to 4**

Biceps: _____

Triceps: _____

Brachioradialis: _____

Patellar: _____

Achilles: _____

Bilateral plantar reflex (upgoing/downgoing) - Specify below:

OTHER OBSERVATIONS

Pupillary response (size, equality, reactivity to light):

Any abnormal movements or posture: _____

Any signs of focal cortical functioning:

Other:

Physician's name: _____

Signature: