Neurological Vital Signs

PATIENT INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy

Medical Record #: _____

VITAL SIGNS

Pulse Rate: _____ Blood Pressure: _____

Respiratory Rate: _____ Body Temperature: _____

MOTOR RESPONSE

Upper Extremities:

Right: _____ Left: _____

Lower Extremities:

Right: _____ Left: _____

CRANIAL NERVES

I. Olfactory (Smell): _____ II. Optic (Vision): _____

III. Oculomotor (Eye Movement): _____ IV. Trochlear (Eye Movement): _____

V. Trigeminal (Facial Sensation): _____ VI. Abducens (Eye Movement): _____

VII. Facial (Facial Movement): _____

VIII. Vestibulocochlear (Hearing/Balance):

IX. Glossopharyngeal (Swallowing): _____

X. Vagus (Swallowing, Speech):

XI. Accessory (Head Movement): _____ XII. Hypoglossal (Tongue Movement): _____

PUPILLARY REACTION

Pupil Size:

Right: _____ Left: _____

Reaction to Light:

Right: _____ Left: _____

BRAIN STEM FUNCTION

Reflexes: _____ Deep Tendon Reflexes: _____

Babinski Reflex: _____

Facial Movements:

Smile: _____ Frown: _____

SENSORY RESPONSES

Touch Sensation:

Right: _____ Left: _____

Pain Sensation:

Right: _____ Left: _____

LEVEL OF CONSCIOUSNESS

Alertness: _____ Responsiveness: _____

Orientation: _____

VERBAL RESPONSE

Speech Clarity: _____ Language Comprehension: _____

Coherence: _____

ADDITIONAL NOTES

Additional Notes: