Neurological Assessment

History
Date _____________ Time _____________
First Name ____________________ MI __ Last Name __________________________

Conduct F A S T (check areas of abnormal findings)
☐ Facial Symmetry ☐ Arms ☐ Speech/Sudden Headache ☐ Time (activate EMS)

Complete S A M P L E (note responses in spaces provided)
Signs and Symptoms ______________________________________________________
Allergies ________________________________________________________________
Medications ______________________________________________________________
Pre-existing conditions ____________________________________________________
Last oral intake (what and time) ___________________________________________
Events leading up to incident ______________________________________________

For Divers:
Dives during previous 24 hours:
Last dive – Depth _____ Bottom Time _____ Breathing Gas __________
Surface interval __________
Previous dive – Depth _____ Bottom Time _____ Breathing Gas __________
Surface interval __________
Previous dive – Depth _____ Bottom Time _____ Breathing Gas __________
Surface interval __________
Previous dive – Depth _____ Bottom Time _____ Breathing Gas __________
Surface interval __________
Previous dive – Depth _____ Bottom Time _____ Breathing Gas __________

Unusual features of any dive ______________________________________________
Did the diver use (check as applicable): ☐ Computer ☐ Dive Tables ☐ Other

Location of any pain ______________________________________________________
Does movement change level of pain? (circle one)       Yes      No

NOTE: attach dive buddy and/or witness comments: _________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Emergency Hotline (+1-919-684-9111)
**Vital Signs**

- Pulse ________
- Respiration rate ________

**Mental Function**

**Consciousness (check one):**
- Alert
- Verbal
- Pain
- Unresponsive

**Orientation (check erroneous answers):**
- What is your name?
- Where are you?
- What is the day and time?
- Why are you here?

- Ability to follow commands (check one)
  - Yes
  - No
  “Stick out your tongue and close your eyes.”
- Ability to repeat a simple phrase
  - Yes
  - No
  Ex.: “no if, ands, or buts.”
- Name 3 objects (able to complete – check one)
  - Yes
  - No
  Ex.: Father/Son, Student/Teacher, Pencil/Paper
- Abstract reasoning (able to explain relationship)
  - Yes
  - No
  Ex.: Father/Son, Student/Teacher, Pencil/Paper
- Calculations - count backwards from 100 by 7s (circle misses):
  93, 86, 79, 72, 65, 58, 51, 44, 37, 30, 23, 16, 9, 2
- Memory - recall of 3 items identified earlier (check one)
  - Yes
  - No

**Cranial Nerves**

- Eyes (circle any direction unable to look): Left, Right, Up, Down
- Facial Symmetry “Close your eyes and smile”
  - Yes
  - No
- Hearing Symmetrical from about 1 foot (circle one)
  - Yes
  - No

**Motor Function**

- Scale (note in blank next to area): Normal (N) Weak (W) Paralysis (P)

  **Upper Body**
  - Shoulders  L____ R____
  - Biceps  L____ R____
  - Triceps  L____ R____
  - Finger spread  L____ R____
  - Grip Strength  L____ R____

  **Lower Body**
  - Hip-Flexors  L____ R____
  - Quadriceps  L____ R____
  - Hamstrings  L____ R____
  - Foot – up  L____ R____
  - Foot – down  L____ R____

**Coordination and Balance**

- Able to complete: Finger – Nose – Finger (check one)
  - Yes
  - No
- Walk (check one)
  - Normal
  - Wobbly
  - Unable
- Romberg (check one)
  - Yes
  - No

**Exam Repeated**

- Time _______________
- Comments ____________________
- Time _______________
- Comments ____________________

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