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 _____

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Surface interval _____

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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: _____

_____

_____

_____

NEURO

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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

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____	**Lower Body**	Hip-Flexors	L____	R____
	Biceps	L____	R____		Quadriceps	L____	R____
	Triceps	L____	R____		Hamstrings	L____	R____
	Finger spread	L____	R____		Foot – up	L____	R____
	Grip Strength	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 _____