Neurology Exam

Patient Name: _____ DOB: _____ CC/Reason for Visit: _____
Neuro/Psych Medications:

Orientation:
AO x____
Person (1)
Place (1)
Time (1)
Situation (1)

Sensation: (+/-)

	RUE	LUE	LLE
RLE			
Gross Touch			
Pain/Temp			
Vib/Propio			
Romberg			
Special Tests			

Cranial Nerves: (+/-)
CN II
CN III
CN IV
CN V
CN VI
CN VII
CN VIII
CN IX
CN X
CN XI
CN XII

Motor: (0-5/5)

	RUE	LUE	LLE	RLE
ROM				
Abduction				
Adduction				
Extension				
Flexion				
Fingers	Feet			

Special Tests

Gait:
General _____
Heel Walk _____
Toe Walk _____
Tandem _____

Reflexes: 0-2+/clonus/tone
Upper
Biceps
Brachioradialis
Triceps
Lower
Patellar
Achilles
Special Reflexes: Jaw-jerk, glabellar