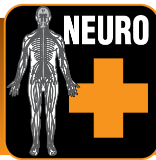

Neurological Assessment

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: _________________________

____

____

____

NEURO

Neurological Assessment

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."

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				**Lower Body**		
	Shoulders	L____	R____	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 ________________________________

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