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NEUROLOGICAL EVALUATION FORM

Patient's Complete Name: _____

Please provide <u>detailed</u> answers to the following questions:

1. What is the diagnosis of the patient? Is this inherited, congenital or acquired?

_____

2. Can you list down all **<u>physical and mental/neurologic</u>** disabilities of the patient as a result of his illness/accident?

_____
_____
_____

3. What are the daily living activities that the patient can perform? Can the patient…

YES	NO	
___	___	a) wash, bathe, and/or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained?
___	___	b) put on and take off, secure and unfasten all necessary garments and any braces, artificial limb or other surgical appliances?
___	___	c) move from a bed to an upright chair or wheelchair and vice versa or get on and off a toilet or commode?
___	___	d) move from one room to another on a level surface, in the patient's normal place of residence?
___	___	e) manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained?
___	___	f.) feed himself once food and drink have been prepared and made available?

4. Does patient have language deficits, spoken or written?

_____
_____

5. Does patient have communication problem in expressing and understanding?

_____
_____

6. Does patient suffer from headaches, seizure, easy fatigability, sleep disorder?

_____
_____

7. Does patient show inappropriate behavior, impaired social skills, unstable emotion?

_____
_____

8. Does patient have problems with cognition?

- Thinking _____
- Reasoning _____
- Information processing _____
- Memory Loss _____
- Problem Solving _____

9. What are the results of the most recent diagnostic examinations done on the patient? (e.g. CT scan,MRI, Blood test, ECG, and Chest XRay) Please indicate inclusive dates.

_____
_____
_____

I hereby certify that the answers given above are full, complete and true.

_____ _____

Physician's Full Name and & Signature Date Signed

License / PTR No.: _____

Valid until : _____

Hospital/Clinic Address: _____