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# Neurological Evaluation Form

Patient's Complete Name: _____

Please provide detailed 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 physical and mental/neurologic 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. What is the prognosis of the patient?

_____

_____

5. In your opinion, will the patient's condition be permanent? ☐ YES ☐ NO

If NO, please indicate how likely the patient's condition be permanent: _____
(from 0% to 100%, higher percentage = greater chance of being permanent)

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 Sol ving _____

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

License / PTR No.: _____
Valid until : _____

Hospital/Clinic Address: _____