CLAIMANT:
CASE NUMBER:

NEUROLOGICAL

1. Please attach medical records including lab reports
   from ______________ to __________________

2. Diagnosis:____
   ____
   ____

3. Date of onset of symptoms: ______________________________

4. Prognosis: ____
   ____
   ____

5. Is there a disturbance of speech? ☐ Yes ☐ No
   If yes, can the patient's speech be understood by strangers? ☐ Yes ☐ No
   Please describe the patient's speech disturbance.
   ____
   ____

6. Is expressive or receptive aphasia present? ☐ Yes ☐ No
   If yes, please indicate which type and comment on severity.
   ____
   ____

7. Are there any reflex abnormalities? ☐ Yes ☐ No
   If yes, please describe. ______________________________
   ____
   ____

8. Please indicate extremities affected by tremor and/or weakness and grade severity using these ratings:

   0/5 - no muscular contraction detected
   1/5 - barely detectable trace or flicker of contraction
   2/5 - active movement of the body part with gravity eliminated
   3/5 - active movement against gravity
   4/5 - active movement against gravity and some resistance
   5/5 - active movement against full resistance without fatigue (normal strength)

   ______ Left Upper Extremity ______ Right Upper Extremity

   ______ Left Lower Extremity ______ Right Lower Extremity

9. Is there any loss of use of extremities? ☐ Yes ☐ No
If yes, please describe severity and extremity involved. ________________

10. If there is any loss of the patient's ability to use the hands for fingering or handling, please describe. ________________

11. If contractures are present, please describe. ________________

12. If there is any disturbance of gait, please describe. ________________

13. Is an assistive device necessary for ☐ Standing? ☐ Walking?
If so, type of assistive device: ________________
Medical basis for use of assistive device: ________________
Impairment affects ☐ Left ☐ Right ☐ Both lower extremities.
Circumstances when device is required: ________________

Do upper extremity limitations affect ability to lift/carry w/ free hand? ☐ Yes ☐ No
If yes, describe: ________________

14. If atrophy is present, please describe. ________________

15. If sensory and/or motor abnormalities are present, please describe. ________________

16. Have there been any seizures in the past 12 months? ☐ Yes ☐ No
If yes, indicate frequency and type. ________________

a. Do these seizures occur despite medication? ☐ Yes ☐ No
b. Is patient compliant with anticonvulsant medication? ☐ Yes ☐ No
Medication blood level/date: ________________

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17. If present, please specify type and degree of ocular involvement. ______________
____
____

18. If present, please comment on any loss of cognitive ability, personality change, abnormal behavior or mood. _______________________________
____
____

19. If a mental impairment is present, is this patient capable of managing benefits in his/her own behalf? ☐ Yes ☐ No.

20. Additional comments:

____

____

____

____

____

Thank you for your cooperation.

Physicians Signature ______________________________

Print/type name ______________________________

Date ______________________

Phone Number (___) ______________ Best time to call ______________