

Neurological Evaluation Form

Dog's name: _____

Date: _____

Visual observations:

(P=present, A=absent, L=limited)

<input type="checkbox"/>	Voluntary limb movemt. (specify limb)
<input type="checkbox"/>	Bowel and bladder control
<input type="checkbox"/>	Neck guarding
<input type="checkbox"/>	Back guarding
<input type="checkbox"/>	Scuffed toes or nails
<input type="checkbox"/>	Ataxia
<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	Balance on displacement
<input type="checkbox"/>	Tone in tail
<input type="checkbox"/>	Panniculus
<input type="checkbox"/>	Anal/perineal reflex

Placing reflexes:

(N=normal, S=slow, A=absent)

<input type="checkbox"/>	Right front
<input type="checkbox"/>	Left front
<input type="checkbox"/>	Right hind
<input type="checkbox"/>	Left hind

Muscle reflexes:

(N=normal, Hyper, Hypo, A=absent)

Right	Left	
<input type="checkbox"/>	<input type="checkbox"/>	Biceps
<input type="checkbox"/>	<input type="checkbox"/>	Triceps
<input type="checkbox"/>	<input type="checkbox"/>	Forearm flexors
<input type="checkbox"/>	<input type="checkbox"/>	Forearm extensors
<input type="checkbox"/>	<input type="checkbox"/>	Deltoid
<input type="checkbox"/>	<input type="checkbox"/>	Gluteals / TFL
<input type="checkbox"/>	<input type="checkbox"/>	Biceps femoris
<input type="checkbox"/>	<input type="checkbox"/>	Semimemb/Tend
<input type="checkbox"/>	<input type="checkbox"/>	Gracilis/Pectineus
<input type="checkbox"/>	<input type="checkbox"/>	Tibialis anterior
<input type="checkbox"/>	<input type="checkbox"/>	Calcaneal tendon
<input type="checkbox"/>	<input type="checkbox"/>	Patellar tendon
<input type="checkbox"/>	<input type="checkbox"/>	Vastus lateralis

Pain: (P=present, A=absent, ?=questionable)

<input type="checkbox"/>	Neck pain (specify location)
<input type="checkbox"/>	Thoracic spine pain (specify location)
<input type="checkbox"/>	Lumbar spine pain (specify location)
<input type="checkbox"/>	Sacral/coccygeal pain (specify location)

Determination of location of lesion

Front limb UMNL: (Y=yes, N=no, ?=quest.)

Right	Left	
<input type="checkbox"/>	<input type="checkbox"/>	Hyper-reflexic
<input type="checkbox"/>	<input type="checkbox"/>	Hyper-metric/spastic
<input type="checkbox"/>	<input type="checkbox"/>	+ Crossed extensor
<input type="checkbox"/>	<input type="checkbox"/>	+ Flexor withdrawal
<input type="checkbox"/>	<input type="checkbox"/>	Deep pain?

Hind limb UMNL: (Y=yes, N=no, ?=quest.)

Right	Left	
<input type="checkbox"/>	<input type="checkbox"/>	Hyper-reflexic
<input type="checkbox"/>	<input type="checkbox"/>	Hyper-metric/spastic
<input type="checkbox"/>	<input type="checkbox"/>	+ Crossed extensor
<input type="checkbox"/>	<input type="checkbox"/>	+ Flexor withdrawal
<input type="checkbox"/>	<input type="checkbox"/>	Deep pain?

Front limb LMNL: (Y=yes, N=no, ?=quest.)

Right	Left	
<input type="checkbox"/>	<input type="checkbox"/>	Hypo-reflexic/a-reflexic
<input type="checkbox"/>	<input type="checkbox"/>	- Crossed extensor
<input type="checkbox"/>	<input type="checkbox"/>	- Flexor withdrawal
<input type="checkbox"/>	<input type="checkbox"/>	Deep pain?

Hind limb LMNL: (Y=yes, N=no, ?=quest.)

Right	Left	
<input type="checkbox"/>	<input type="checkbox"/>	Hypo-reflexic/a-reflexic
<input type="checkbox"/>	<input type="checkbox"/>	- Crossed extensor
<input type="checkbox"/>	<input type="checkbox"/>	- Flexor withdrawal
<input type="checkbox"/>	<input type="checkbox"/>	Deep pain?

Bowel & bladder UMNL: (Y=yes, N=no, ?=quest.)

<input type="checkbox"/>	Problems urinating
<input type="checkbox"/>	Bladder hard to express
<input type="checkbox"/>	Bladder reflexic (squirty)
<input type="checkbox"/>	+ Anal/perineal reflex

Bowel & bladder LMNL (Y=yes, N=no, ?=quest)

<input type="checkbox"/>	Problems urinating
<input type="checkbox"/>	Bladder - overflow incontinence
<input type="checkbox"/>	Large, distended bladder
<input type="checkbox"/>	- Anal/perineal reflex

Therapist name (print): _____

Therapist signature: _____