

# Neuro Assessment Documentation

## Patient Information:

**Name:** Emmanuel Miller

**Age:** 45

**Gender:** Male

**Date of Assessment:** February 20, 2024

**Medical History:** Hypertension, Type 2 Diabetes

## Chief Complaint/Reason for Assessment:

Patient presents with persistent headaches and episodes of dizziness.

## 1. Mental Status Examination:

- **Appearance and behavior:** Alert and cooperative
- **Level of consciousness:** Alert and oriented x3
- **Orientation to person, place, time:** Oriented to person, place, and time
- **Memory:** Recent and remote memory intact
- **Attention and concentration:** Able to maintain attention
- **Language and speech:** Speech fluent with no abnormalities noted
- **Executive function:** Able to follow commands and complete tasks

## 2. Cranial Nerve Examination:

- **Cranial Nerve I (Olfactory):** Intact, able to identify scents
- **Cranial Nerve II (Optic):** Visual acuity within normal limits
- **Cranial Nerve III (Oculomotor):** Pupils equal, round, and reactive to light and accommodation
- **Cranial Nerve IV (Trochlear):** Normal extraocular movements
- **Cranial Nerve V (Trigeminal):** Sensation intact bilaterally
- **Cranial Nerve VI (Abducens):** Normal extraocular movements
- **Cranial Nerve VII (Facial):** Symmetric facial movements, able to close eyes tightly
- **Cranial Nerve VIII (Vestibulocochlear):** Able to hear whispered words bilaterally
- **Cranial Nerve IX (Glossopharyngeal):** Normal gag reflex
- **Cranial Nerve X (Vagus):** Palate elevation symmetric
- **Cranial Nerve XI (Accessory):** Normal shoulder shrug strength
- **Cranial Nerve XII (Hypoglossal):** Tongue midline with no deviation

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**M Woodhall**



## **Neuro Exam Documentation Example:**

Guide to Clinical Documentation Debra D Sullivan, 2018-07-25 Understand the when why and how Here s your guide to developing the skills you need to master the increasing complex challenges of documenting patient care Step by step a straightforward how to approach teaches you how to write SOAP notes document patient care in office and hospital settings and write prescriptions You ll find a wealth of examples exercises and instructions that make every point clear and easy to understand

*Evidence-Based Physical Examination Handbook* Kate Gawlik, Bernadette Mazurek Melnyk, Alice Teall, 2024-03-22 Leading the way in providing evidence based assessment guidance to prepare clinicians for their future in healthcare This unique resource combines scientific and holistic approaches to assessment and integrates best practices to guide history taking and physical exam Utilizing the evidence and summarizing clinical relevance this handbook guides the incorporation of the most current evidence based assessment guidelines from such sources as the U S Preventative Services Task Force Chapters have a consistent structure and include key history questions and considerations evidence based physical examination techniques red flag signs and symptoms differential diagnoses for both normal and abnormal findings and sample documentation There are extensive color illustrations and photographic images to strengthen and support advanced assessment skills New to the Second Edition Completely new chapters reflecting specific lifespan considerations including the child adolescent and older adult Increased coverage of evidence based documentation Expanded coverage in every chapter regarding changing practice environments Focus on inclusive history taking and assessment techniques including considerations for diverse populations and social determinants of health Key Features Includes focus on evidence to enable highest quality of care Emphasizes the importance of wellness and the assessment of well being Delivers the evidence acceptability and clinical relevance behind history taking and physical examination techniques Focuses on the most current clinical guidelines from sources such as the U S Preventive Services Task Force Demonstrates techniques with valuable illustrations and photographic images

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