CNS Assessment

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_

Today's Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_ Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you able to drive? Yes Partially No

Are you able to work or study? Yes Partially No

Are you able to sustain a close relationship? Yes Partially No

Please fill out the list of symptoms below; indicate the frequency (or degree) to which you feel each symptoms using **0** (to mean, *not at all*) to **10** (to mean, all the time).

If either of your parents also had, or has, the symptom, please check the “Parent” column.

If the symptom came on suddenly, please check the “Suddenly” column.

(This reference is only necessary the first time the questions are answered.)

Degree or

Frequency (0 - 10) Parent Suddenly

**- Sensory –** (sensations *without* a known *physiological* cause)

How sensitive are you to light? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Are your “smell” senses either diminished or intense? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you see speckles, spots, patterns, etc? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you hear whistles, pops, buzzing, etc? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do feel burning, itching, pain, tickles, etc? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

**- Emotions -**

Have you experienced unexplained mood changes? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have unexplained fearfulness? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have unexplained spells of depression? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have unexplained spells of elation? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Are you ever explosive? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have suicidal thoughts or actions? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Degree or

Frequency (0 - 10) Parent Suddenly

**- Clarity -**

Do you ever feel “foggy”? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble following conversations? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you get confused? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble following what you read? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble concentrating? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you procrastinate and/or lack of initiative? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble being attentive? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble managing multiple parts? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble prioritizing? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble *not finishing* what you start? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble organizing spaces & things? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you cover-up *not knowing* what has been said? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

**- Energy -**

Do you have trouble with stamina? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you find yourself fatigued during the day? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble falling asleep? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble staying asleep? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble falling back to sleep? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

**- Movement -**

Do you have paralysis? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you get eye-strain fatigue? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have double-vision? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Degree or

Frequency (0 - 10) Parent Suddenly

**- Pain -**

Does the outside of your head hurt? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have throbbing head pain? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have shoulder pain? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have neck pain? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have wrist pain? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have tender muscle areas? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have all-over pain? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have joint pain? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Any other pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

**- Memory -**

Do you forget what you have just heard? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you forget what you’re doing or need to do? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you trouble learning from experience? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

**- Activation / Anxiety -**

Are you restlessness? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you get irritable? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you day dream? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you worry? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Are you always moving around? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you get cold hands and/or feet? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you get heart palpitations? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_