

Equine Neurological Exam Form

Patient ID _____ **Horse Name** _____
Horse Age _____ **Breed** _____ **Sex** _____ **Use** _____
Veterinarian Performing Exam _____ **Date** _____

History _____

Onset, progression, diagnostics performed, response to any treatments

Comments

Physical Exam _____

Temp	Pulse	Resp
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Comments

Mental Status _____

- Alert and responsive No Yes
- Lethargic No Yes
- Stuporous No Yes
- Semi-comatose No Yes
- Comatose No Yes
- Delirious No Yes

Comments

Behavior _____

- Behavior change No Yes
- Compulsive yawning No Yes
- Compulsive circling No Yes
- If so, to R or L?* Right Left
- Head Pressing No Yes
- Seizures No Yes

Comments

Head Evaluation _____

- Head Tilt No Right Left
- Head Turn No Right Left
- Intention Tremor No Yes

Comments

Eyes _____

	LEFT		RIGHT		
Ophthalmic Exam	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Vision	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Menace	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Pupil size/symmetry	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Pupillary light response	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Horner's syndrome	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> N/A
Strabismus	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> N/A

Comments

Eye drop	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Physiologic nystagmus	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Resting nystagmus	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> N/A
Positional nystagmus	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> N/A

Comments

Face	LEFT		RIGHT		
Sensation	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Muscle mass, jaw tone	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Facial expression	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Palpebral reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Comments					

Hearing	LEFT		RIGHT		
	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Comments					

Tongue, Pharynx, Larynx	LEFT		RIGHT		
Muscle tone, mass	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Swallow	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Comments					

Body Evaluation	LEFT		RIGHT		
Cervicofacial reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Cutaneous trunci	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Perineal sensation	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Tail tone	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Anal tone	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Areas of abnormal sweating	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	
Comments					

Slap test/Scope	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Neck flexion	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Neck muscle mass	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Forelimb muscle mass	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Hindlimb muscle mass	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Epaxial muscle mass	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Forelimb posture	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Hindlimb posture	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Forelimb hoofwear	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Hindlimb hoofwear	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> N/A
Comments					

Patient ID _____

Date _____

Gait Evaluation (at walk)

Truncal sway	<input type="checkbox"/> Absent	<input type="checkbox"/> Present			
Toe dragging	<input type="checkbox"/> LF	<input type="checkbox"/> RF	<input type="checkbox"/> LH	<input type="checkbox"/> RH	<input type="checkbox"/> N/S
Inconsistent limb placement	<input type="checkbox"/> LF	<input type="checkbox"/> RF	<input type="checkbox"/> LH	<input type="checkbox"/> RH	<input type="checkbox"/> N/S
Inconsistent stride length	<input type="checkbox"/> LF	<input type="checkbox"/> RF	<input type="checkbox"/> LH	<input type="checkbox"/> RH	<input type="checkbox"/> N/S
Dysmetria	<input type="checkbox"/> LF	<input type="checkbox"/> RF	<input type="checkbox"/> LH	<input type="checkbox"/> RH	<input type="checkbox"/> N/S
Limb interference	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Standing tail pull	<input type="checkbox"/> Normal	<input type="checkbox"/> Weak left	<input type="checkbox"/> Weak right	<input type="checkbox"/> N/A	
Walking tail pull	<input type="checkbox"/> Normal	<input type="checkbox"/> Weak left	<input type="checkbox"/> Weak right	<input type="checkbox"/> N/A	

Comments

Circling left (<i>counterclockwise</i>):	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal		<input type="checkbox"/> N/A	
Circumduction	<input type="checkbox"/> Absent	<input type="checkbox"/> Present			
Toe dragging	<input type="checkbox"/> LF	<input type="checkbox"/> RF	<input type="checkbox"/> LH	<input type="checkbox"/> RH	<input type="checkbox"/> N/S
Interference/Crossing over hindlimbs	<input type="checkbox"/> Absent	<input type="checkbox"/> Present			
Pivoting	<input type="checkbox"/> Absent	<input type="checkbox"/> Present		<input type="checkbox"/> N/A	

Comments

Circling right (<i>clockwise</i>):	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal		<input type="checkbox"/> N/A	
Circumduction	<input type="checkbox"/> Absent	<input type="checkbox"/> Present			
Toe dragging	<input type="checkbox"/> LF	<input type="checkbox"/> RF	<input type="checkbox"/> LH	<input type="checkbox"/> RH	
Interference/Crossing over hindlimbs	<input type="checkbox"/> Absent	<input type="checkbox"/> Present			
Pivoting	<input type="checkbox"/> Absent	<input type="checkbox"/> Present		<input type="checkbox"/> N/A	

Comments

Backing	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal		<input type="checkbox"/> N/A	
Foot dragging	<input type="checkbox"/> LF	<input type="checkbox"/> RF	<input type="checkbox"/> LH	<input type="checkbox"/> RH	
Pacing	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Basewide limb	<input type="checkbox"/> No	<input type="checkbox"/> Yes			

Head elevation	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal		<input type="checkbox"/> N/A	
Serpentine	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal		<input type="checkbox"/> N/A	
Hill/Curb	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal		<input type="checkbox"/> N/A	
Blindfold	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal		<input type="checkbox"/> N/A	
Hopping	<input type="checkbox"/> Normal	<input type="checkbox"/> Weak LF	<input type="checkbox"/> Weak RF	<input type="checkbox"/> N/A	

Comments

Ataxia Grade

- 0 1 2 3 4 5

Neuroanatomical Localization

- Focal Multifocal Diffuse
 Cerebrum Brainstem Cerebellum Spinal cord Peripheral Musculoskeletal

Specific:

Differential Diagnoses

Diagnostic Plan

Treatment Plan