

Assessor's name: _____

Job Title: _____

Neurobehavioral Pre-Assessment Checklist

Name	
Preferred name/Nickname	
Date of Birth	
Hand Dominance	
Native Language	
Cultural/Religious considerations	

Medical Condition and Assistive Devices

	Yes	No	Comments/Concerns
Hearing Devices	<input type="checkbox"/>	<input type="checkbox"/>	
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	
Orally Intubated	<input type="checkbox"/>	<input type="checkbox"/>	
Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	
If tracheostomy, use of speaking valve	<input type="checkbox"/>	<input type="checkbox"/>	
Supplemental Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	
Ventilatory support	<input type="checkbox"/>	<input type="checkbox"/>	
Metabolic disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Please list any relevant premorbid medical history			

Please take the following conditions into consideration that may influence the neurobehavioral assessment results.

Motor	Cognitive	Sensorial	Neurological/ Neurosurgical	Behaviour
<ul style="list-style-type: none"> • Spinal cord injury • Neuropathy/myopathy • Tremor/Myoclonus • Spasticity/retractions • Fractures • Others: 	<ul style="list-style-type: none"> • Aphasia • Apraxia • Agnosia • Others: 	<ul style="list-style-type: none"> • Blindness • Deafness • Others: 	<ul style="list-style-type: none"> • Uncontrolled seizures • Active hydrocephalus • Craniectomy • Ptosis* • Others: <p style="font-size: small; margin-top: 10px;"><i>*If suspected ptosis, consider manual eye opening</i></p>	<ul style="list-style-type: none"> • Agitation/aggressivity • Paroxysmal sympathetic hyperactivity • Suspected pain or discomfort • Others:

Note: this checklist can be applied prior to any assessment scale

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Assessment				
Date				AM / PM
Assessment scale used				
Hospital ward or Home (please specify)				
Prior to starting assessment, please consider:				
	Yes	No	N/A	Comments
Best time for patient's responsiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rest period prior to session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family involvement/input/presence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Familiar stimuli identified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Location of assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
"Do not disturb" sign up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Adequate Temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Adequate Lighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Minimize noise (<i>music/tv off</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Door closed/close curtains if not single room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Tracheal suctioning needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sedative meds administered prior to session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Acute illness/fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin integrity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patient's wakefulness (<i>i.e., eye opening; needed prompts to wake up</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Remove splints/casts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Remove sheets from covering body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
At least 1 min observation prior to session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Documented affective responses (<i>e.g. smile, grimace, etc</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patient Testing Position				
(Reposition as needed to maintain optimal positioning, avoid discomfort, and avoid fatigue)				
<input type="checkbox"/> Supine <input type="checkbox"/> Supine with head of bed elevated (please specify degree of incline____)				
<input type="checkbox"/> Sitting in wheelchair <input type="checkbox"/> Sitting on the mat				
<input type="checkbox"/> Supported standing <input type="checkbox"/> Other: _____				

Note: this checklist can be applied prior to any assessment scale