

# 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

<b>Face</b>	<b>LEFT</b>		<b>RIGHT</b>		
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					

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

<b>Tongue, Pharynx, Larynx</b>	<b>LEFT</b>		<b>RIGHT</b>		
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					

<b>Body Evaluation</b>	<b>LEFT</b>		<b>RIGHT</b>		
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

Patient ID \_\_\_\_\_

Date \_\_\_\_\_

**Ataxia Grade**

- 0     1     2     3     4     5

**Neuroanatomical Localization**

- Focal         Multifocal     Diffuse  
 Cerebrum     Brainstem     Cerebellum    Spinal cord    Peripheral     Musculoskeletal

Specific:

**Differential Diagnoses**

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**Diagnostic Plan**

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**Treatment Plan**

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This evaluation created through the cooperation of Amy Johnson, DVM, DACVIM; Robert MacKay BVSc, PhD, DACVIM; Nicola Pusterla, DVM, PhD, DACVIM; Steve Reed, DVM, DACVIM; and Sarah Reuss, VMD, DACVIM.

