

# Reflex Test

## Patient Information

- Patient Name:
- Date of Birth:
- Medical Record Number:
- Date of Examination:
- Healthcare Provider:
- Contact Information:

## Reflex Assessment

- Reflex Tested (e.g., Patellar, Biceps, Triceps):
- Left Side Response:
- Right Side Response:

## Interpretation

- Normal Response
- Hyperreflexia
- Hypo- or Areflexia
- Asymmetrical Responses
- Clonus
- Sustained Clonus
- Spreading Reflexes
- Involuntary Movements

**Additional Notes**

**Conclusion**

Provide a brief clinical assessment or diagnosis (if applicable) based on the reflex test results.

**Patient Consent**

I, the undersigned, consent to the reflex test the healthcare provider performs. I understand the purpose of this test and its role in my diagnosis and treatment.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Healthcare Provider Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_