

**Modified Mayhew Scale
Neurological Examination Form**

Case ID: _____ Horse Name: _____

Breed: _____ Sex: M MC F Body Weight: _____ lbs.

Date: _____ Day on Study: _____ Tape# _____

- 1) Appetite:
 Food Consumption: Normal Abnormal
 Water Consumption: Normal Abnormal

- 2) Attitude/Behavior:
- | | | |
|----------------------|-----------------------------|------------------------------|
| Anxious | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Apprehensive | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Convulsions | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Depressed | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Head Pressing | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Nose or lip wrinkled | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Shaking Head | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Tongue Hanging Our | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

- 3) Head Evaluation:
- | | | |
|------------------------|-----------------------------|------------------------------|
| Tilt | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Non-symmetric | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Lip droop/salivation | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Intention Tremor | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Abnormal Sensation | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Abnormal Swallow (gag) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Abnormal Tongue Tone | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Other:

| Cranial Nerves | Left | | Right | |
|-------------------------|---------------------------------|-----------------------------------|---------------------------------|-----------------------------------|
| Vision | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Pupil size/symmetry | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Pupillary light reflex | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Menace Response | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Blink to Bright light | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Corneal Reflex | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Physiologic Strabismus | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Physiologic Nystagmus | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Facial Muscle Tone | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Mastication Muscle Tone | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |

4) Body Evaluation:

| Body Sensation | Left | | Right | |
|----------------|---------------------------------|-----------------------------------|---------------------------------|-----------------------------------|
| Neck | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Trunk | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Limbs | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Quarter | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Perianal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |

| Muscle Tone | Left | | Right | |
|--------------|---------------------------------|-----------------------------------|---------------------------------|-----------------------------------|
| Neck | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Back | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Limbs | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Quarter | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Tail | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Other: _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |

**Modified Mayhew Scale
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Case ID: _____ Horse Name: _____

Date: _____ Day on Study: _____ Tape: _____

5) Gait Evaluation:

| <u>Gait Symmetry (describe):</u> | <u>Walking:</u> | | <u>Worsens with Head Raised:</u> | |
|--|-----------------------------|------------------------------|----------------------------------|------------------------------|
| Truncal Swaying | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Toe dragging (if yes, which limb(s): _____) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

| | | | | |
|---|-----------------------------|------------------------------|-----------------------------|------------------------------|
| Inconsistent Limb Placement | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Limb Interference (if yes, which limb(s): _____) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

| | | | | |
|--------|-----------------------------|------------------------------|-----------------------------|------------------------------|
| Pacing | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|--------|-----------------------------|------------------------------|-----------------------------|------------------------------|

| | | | | |
|-----------------------|-----------------------------|------------------------------|-----------------------------|------------------------------|
| Spasticity | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Circling left: | | | | |
| Circumduction RR limb | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | |
| Toe dragging | <input type="checkbox"/> No | <input type="checkbox"/> Yes | (if yes, which limb: _____) | |
| Other: _____ | | | | |

| | | | | |
|------------------------|-----------------------------|------------------------------|-----------------------------|--|
| Circling right: | | | | |
| Circumduction LR limb | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | |
| Toe dragging | <input type="checkbox"/> No | <input type="checkbox"/> Yes | (if yes, which limb: _____) | |
| Other: _____ | | | | |

| <u>Placing Reactions:</u> | <u>Left</u> | | <u>Right</u> | |
|---------------------------|---------------------------------|-----------------------------------|---------------------------------|-----------------------------------|
| Front | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Rear | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| <u>Hoofwear:</u> | | | | |
| Front | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Rear | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |

| | | | |
|------------------------|-----------------------------|------------------------------|--------------------------------|
| <u>Backing:</u> | | | |
| Toe dragging | <input type="checkbox"/> No | <input type="checkbox"/> Yes | (if yes, which limb(s): _____) |
| Pacing | <input type="checkbox"/> No | <input type="checkbox"/> Yes | (if yes, which limb(s): _____) |
| Inconsistent Placement | <input type="checkbox"/> No | <input type="checkbox"/> Yes | (if yes, which limb(s): _____) |

| | | | |
|---------------------|---------------------------------|-------------------------------------|----------------------------------|
| Tail Pull | <input type="checkbox"/> Strong | <input type="checkbox"/> Weak | |
| Lesion Localization | <input type="checkbox"/> Focal | <input type="checkbox"/> Multifocal | <input type="checkbox"/> Unclear |

Site of Lesion _____

Grade Scale for Spinal Ataxia: 0 to 5 (5 being the worst) _____

Veterinarian Signature

Date