An Easy Guide to Head to Toe Assessment

Neurological Assessment

Oriented to: ☐ Person ☐ Place ☐ Time

Communication/ Speech: ☐ WNL ☐ Non-verbal ☐ Dysarthria ☐ Aphasia: ☐ Expressive ☐ Receptive ☐ Global

Pupils: ☐ PERRLA OR

Equal: ☐ Yes ☐ No ☐ R larger ☐ L larger Round: ☐ Yes ☐ No ☐ R abnormal shape ☐ L abnormal shape

Reactive to Light: ☐ Yes ☐ N Reaction: ☐ Brisk ☐ Sluggish ☐ R no reaction ☐ L no reaction

Accommodation: ☐ R ☐ L (hold finger 4" above nose, bring closer to face, do both eyes maintain focus?)

Glasgow Coma Scale (Score range 0 to 15, Coma =< 7)	
Eye opening to:	☐ Spontaneous = 4 ☐ Verbal command = 3 ☐ Pain = 2 ☐ No response = 1
Verbal response to:	☐ Oriented, converses = 5 ☐ Disoriented, converses = 4 ☐ Uses inappropriate words = 3 ☐ Incomprehensible sounds = 2 ☐ No response = 1
Motor response to:	☐ Verbal command = 6 ☐ Localized pain = 5 ☐ Flexes and withdraws = 4 ☐ Flexes abnormally (decorticate) = 3 ☐ Extends abnormally (decerebrate) = 2 ☐ No response = 1

Location	Muscle Tone	Muscle Strength	Sensation	Tremor
Head/ Neck	☐ WNL ☐ Flaccid ☐ Spastic		☐ WNL ☐ To pain ☐ No response to pain	☐ No ☐ Present
R hand	☐ WNL ☐ Flaccid ☐ Spastic			
L hand	☐ WNL ☐ Flaccid ☐ Spastic			
RUE	☐ WNL ☐ Flaccid ☐ Spastic			
LUE	☐ WNL ☐ Flaccid ☐ Spastic			
RLE	☐ WNL ☐ Flaccid ☐ Spastic			
LLE	☐ WNL ☐ Flaccid ☐ Spastic			

Muscle Strength: 5 = WNL 4 = 75% normal 3 = 50% normal 2 = 25% normal 1 = 10% normal 0 = complete paralysis

Respiratory Assessment

Pulse ox: ☐ WNL (95-100%) ☐ WNL for this patient at _____

Cough: ☐ None ☐ Non-productive, dry ☐ Productive ☐ Productive sounding, no sputum

Sputum: ☐ None **Consistency:** ☐ Thick ☐ Thin ☐ Foamy **Color:** ☐ White ☐ Other, _____

Oxygen: ☐ N/A Room air ☐ ____ liters/ nasal cannula ☐ ____ % per face mask ☐ Mechanical ventilator

Respiratory rate: ☐ WNL ☐ Tachypnea/ hyperventilation (too fast) ☐ Bradypneic/ hypoventilation (too slow/ shallow)

Respiratory effort: ☐ Relaxed and regular ☐ Pursed lip breathing ☐ Painful respiration ☐ Labored

☐ Dyspnea at rest ☐ Dyspnea with minimal effort, talking, eating, repositioning in bed, etc.

☐ Dyspnea with moderate exertion, dressing, walking =< 20 feet, etc. ☐ Dyspnea when walking ____ feet or with exercise

Recovery time following dyspneic episode: _____ minutes

Respiratory rhythm: ☐ WNL ☐ Regular, tachypneic ☐ Regular, bradypneic ☐ Regular with periods of apnea

☐ Regular pattern of increasing rate and depth, followed by decreasing rate and depth, followed by apnea (Cheyne-Stokes)

☐ Regular, abnormal, rapid and deep respiration (central neurogenic hyperventilation)

☐ Regular, abnormal, prolonged inspiration with a pause or sigh with periods of apnea (apneustic)

☐ Irregularly irregular pattern/ depth (ataxic) ☐ Irregular with periods of apnea (cluster breathing)

Breath sounds (auscultate anterior & posterior, R & L upper, mid, lower chest)**:**

☐ Clear (vesicular) throughout

☐ Decreased (atelectasis?)

☐ Crackles: ☐ Fine (sounds like hair rubbing) ☐ Coarse/ moist

☐ Gurgles/ rhonci (low pitched, moaning, snoring sounds)

☐ Wheezes: ☐ Inspiratory ☐ Expiratory

☐ Friction rub (sounds like leather rubbing against leather)

☐ Absent (pneumothorax?)

Upper chest: Right _____ Left _____

Mid chest: Right _____ Left _____

Lower chest: Right _____ Left _____

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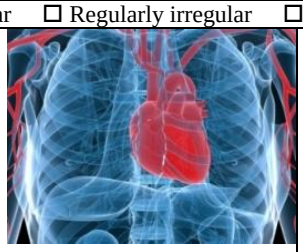
Cardiovascular Assessment

Skin: ☐ Warm/ dry ☐ Cool ☐ Clammy/ diaphoretic **Skin turgor:** ☐ WNL ☐ Tenting **Weight:** _____ kg/ lb

Capillary refill: ☐ WNL ☐ Delayed > 2 seconds

Apical pulse rhythm: ☐ Regular ☐ Regularly irregular ☐ Irregularly irregular

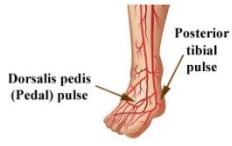
Apical pulse rate:
☐ WNL (60-100)
☐ Bradycardia
☐ Tachycardia
(Extremely low or high HRs decrease C.O., blood and O2 to the vital organs).

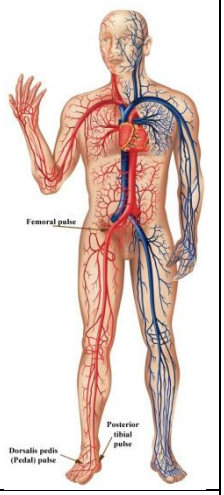


Apical/ radial deficit: ☐ No ☐ Yes

Heart sounds:
☐ Normal S_1S_2 ☐ S_3 (gallop)
☐ Valve click [artificial heart valve]
☐ Murmur:
- ☐ Holosystolic
- ☐ Midsystolic
- ☐ Diastolic

Peripheral Pulses				Edema			
R radial	☐ Yes	☐ Doppler	☐ No	R hand/ arm	☐ No	☐ Non-pitting	☐ Pitting ___+
R femoral	☐ Yes	☐ Doppler	☐ No	R knee to thigh	☐ No	☐ Non-pitting	☐ Pitting ___+
R pedal	☐ Yes	☐ Doppler	☐ No	R ankle to knee	☐ No	☐ Non-pitting	☐ Pitting ___+
R post tib	☐ Yes	☐ Doppler	☐ No	R foot/ ankle	☐ No	☐ Non-pitting	☐ Pitting ___+
L radial	☐ Yes	☐ Doppler	☐ No	L hand/ arm	☐ No	☐ Non-pitting	☐ Pitting ___+
L femoral	☐ Yes	☐ Doppler	☐ No	L knee to thigh	☐ No	☐ Non-pitting	☐ Pitting ___+
L pedal	☐ Yes	☐ Doppler	☐ No	L ankle to knee	☐ No	☐ Non-pitting	☐ Pitting ___+
L post tib	☐ Yes	☐ Doppler	☐ No	L foot/ ankle	☐ No	☐ Non-pitting	☐ Pitting ___+
				Sacrum	☐ No	☐ Non-pitting	☐ Pitting ___+





ECG assessment if applicable, see below

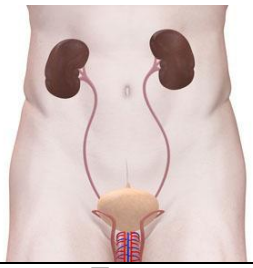
Genitourinary Assessment

Genitalia: ☐ WNL ☐ Abnormalities, describe: _____

Assessment of urination: ☐ WNL ☐ Burning ☐ Frequency ☐ Urgency
☐ Bladder distention ☐ Pelvic pain/ discomfort ☐ Lower back/ flank pain/ discomfort

Continent: ☐ Yes ☐ Stress incontince with coughing, etc. ☐ Rarely incontinent ☐ Regularly incontinent

Urine amount: ☐ WNL (over 30 mls/ hr, output approximates intake)
☐ Less than 30 mls/ hr (dehydration? Post-op volume depletion? SIADH?)
☐ Output greatly exceeds intake (Post-op diuresis? Diabetes insipidus?)



Urine color: ☐ Yellow, WNL ☐ Amber ☐ Orange ☐ Dark amber ☐ Pink ☐ Red tinged ☐ Grossly bloody

Urine characteristics: ☐ Clear, WNL ☐ Cloudy ☐ Sediment ☐ Abnormal odor

Urostomy: ☐ N/A ☐ Urostomy/ ileal conduit ☐ Continence maintaining nipple valve ostomy
Stoma status: ☐ Pink, viable ☐ Red ☐ Deep red ☐ Dusky ☐ Dark ☐ Retracted below skin ☐ S/S of infection

Urinary stents: ☐ N/A ☐ R ureter ☐ L ureter

Urinary catheter: ☐ N/A ☐ Foley, short term ☐ Foley, long term at home
☐ Suprapubic catheter **Insertion site:** ☐ WNL ☐ S/S of infection

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Gastrointestinal Assessment

Oral mucosa: ☐ Intact ☐ Moist ☐ Dry ☐ Pink ☐ Pale **Tongue:** ☐ WNL ☐ Pink ☐ White patches

Abdomen: ☐ WNL ☐ Distended ☐ Taut ☐ Ascites ☐ Abdominal incision **Abdominal girth (PRN):** ____ cm

Abdominal pain, see pain assessment

Bowel movements: ☐ WNL ☐ Constipation ☐ Diarrhea ☐ Bowel program required ☐ Other, _____
(if diarrhea, assess risk for *C. diff* or VRE)

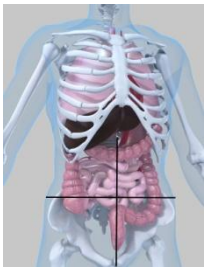
Last bowel movement: ☐ Today ☐ Yesterday ☐ Other, _____

Continent: ☐ Yes ☐ Rarely incontinent ☐ Regularly incontinent

Nausea/ vomiting: ☐ No ☐ Yes, describe: _____

Nutritional intake: ☐ Adequate ☐ Inadequate, address in care planning

Bowel sounds (all four quadrants):
☐ Active, WNL ☐ Hyperactive
☐ Hypoactive ☐ Absent (listen for 5 full minutes)



Tubes: ☐ None ☐ Salem sump ☐ Nasoduodenal feeding tube ☐ PEG tube ☐ Jejunostomy (J) tube pH aspirate: ___
Insertion site: ☐ WNL ☐ Pressure areas ☐ Redness ☐ Purulent drainage ☐ Tenderness ☐ Warmth
Tube feeding: Type: _____ Amount: ____ mls over ____ hours via ☐ Gravity ☐ Pump
☐ Intermittent ☐ Continuous (keep head of bed elevated to prevent aspiration, check placement – pH should be 0 to 4)

Stoma: ☐ N/A ☐ Colostomy ☐ Ileostomy (Notify the surgeon of ***all*** abnormalities observed for new colostomies)
Stoma status: ☐ Pink, viable ☐ Red ☐ Deep red ☐ Dusky ☐ Dark ☐ Retracted below skin ☐ S/S of infection

PEG tube = percutaneous endoscopic gastrostomy tube

Skin Integrity Assessment

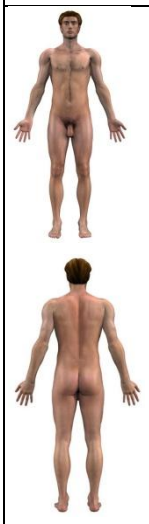
Skin color: ☐ WNL ☐ Pale ☐ Jaundice ☐ Dusky ☐ Cyanotic

Skin is: ☐ Intact ☐ No, see below ☐ No, describe: _____ **Braden Scale Score:** _____

Signs/ symptoms of inflammation/ infection: ☐ Redness ☐ Tenderness/ pain ☐ Warmth ☐ Swelling
Location(s):

Contusion(s)/ Ecchymosis: ☐ N/A **Size:** Length _____ cm Width _____ cm Depth _____ cm
Location(s): _____ **Client's explanation of bruising:** _____

Wounds

Location	Type	Size	Tunneling	Undermining	Surrounding Tissue	Drainage
	☐ Abrasion ☐ Avulsion ☐ Burn ☐ Laceration ☐ Puncture ☐ Pressure ulcer, Stage _____ ☐ Stasis ulcer ☐ Surgical incision, closed, edges are approximated ☐ Surgical, ☐ open areas ☐ total wound dehisence ☐ _____	**Length** ____ cm **Width** ____ cm **Depth** ____ cm **Incision length** _____ cm _____ # of **staples/ sutures** (circle one)	☐ None ☐ Present at _____ o'clock, depth _____ cm ☐ Present at _____ o'clock, depth _____ cm	☐ None ☐ Present, surrounding tissue is: ☐ Dusky ☐ Soft ☐ Boggy ☐ Fluid-full ☐ Other, describe:	☐ WNL ☐ Redness ☐ Tenderness ☐ Pain ☐ Warmth ☐ Streaking ☐ Excoriation ☐ Bruising ☐ Discolored ☐ Dusky **Wound edges** ☐ WNL ☐ Hyperkeratotic	**Color/ Characteristics:** ☐ Serous ☐ Serosanguinous ☐ Bloody ☐ Yellow ☐ Tan ☐ Brown ☐ Green **Purulent?** ☐ No ☐ Yes **Odor?** ☐ No ☐ Yes

Is client on a pressure reduction or relief surface: ☐ No ☐ Yes, type: _____

*Undermining is due to liquefication of necrotic tissue or mechanical forces that sheared and separated underlying tissues.

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Pain Assessment
Location of pain: _____ **Pain is:** ☐ Acute ☐ Chronic ☐ Constant ☐ Intermittent
Pain is affecting: ☐ N/A ☐ Sleep ☐ Activity ☐ Exercises ☐ Relationships ☐ Emotions ☐ Concentration ☐ Appetite ☐ Other: _____
Description of pain: ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Shooting ☐ Burning ☐ Electric-shock like
Pain rating on a scale of 0 to 10: _____ **Acceptable level of pain for this client:** _____ **Highest pain level today:** _____ **Best pain level today:** _____ **Best pain ever gets:** _____
What makes the pain worse? ☐ Activity ☐ Exercises ☐ Other: _____
What makes the pain decrease? ☐ Rest/ sleep ☐ Medication ☐ Heat ☐ Cold ☐ Family presence ☐ Music ☐ Reading ☐ Distraction ☐ Meditation ☐ Guided imagery ☐ Relaxation techniques ☐ Other: _____
Opiod medication(s): _____ **Route:** _____ **Last dose:** _____ **Breakthrough medication(s):** _____ **Route:** _____ **Last dose:** _____ **NSAIDS/ Adjuvants:** _____ **Route:** _____ **Last dose:** _____
PCA: ☐ N/A ☐ Morphine ☐ Dilaudid ☐ Fentanyl via ☐ IV ☐ Epidural, dressing: ☐ D&I ☐ _____ **Continuous dose:** _____ / hr **Demand dose:** _____ every _____ minutes **Max doses per hour:** _____ (Assess pain every 2 to 4 hours, evaluate the # of attempts vs the # of demand doses received to determine if dose is sufficient)
Does the client have concerns about overusing medications/ addiction? ☐ No ☐ Yes, _____

IV Assessment
Type of line: ☐ Peripheral, site _____ ☐ Triple lumen CVL ☐ PICC ☐ Tunneled CVL ☐ Implanted port (check CXR for catheter tip placement before using all new central venous and PICC lines)
Insertion site: ☐ WNL ☐ Redness ☐ Tenderness/ pain ☐ Warmth ☐ Swelling ☐ Drainage (IV needs to be DC'd if s/s of infection, thrombophlebitis or pain is present. Change PIV, notify MD of PIV and CVL concerns)
IV fluids: ☐ N/A, heplock ☐ IV fluids: _____ @ _____ mls/ hr ☐ Continuous ☐ over ___ hrs ☐ IV pump ☐ Dial-a-flo ☐ Gravity
TPN/ PPN: ☐ N/A ☐ TPN ☐ PPN @ _____ mls/ hr ☐ Continuous ☐ over ____ hrs per _____ pump **Blood sugars:** ☐ q 6 hrs ☐ q 8 hrs ☐ other: _____ **Blood sugars ranges:** ☐ WNL ☐ High with coverage needed
PCA: ☐ N/A ☐ Morphine ☐ Dilaudid ☐ Fentanyl via ☐ IV ☐ Epidural, dressing: ☐ D&I ☐ _____ **Continuous dose:** _____ / hr **Demand dose:** _____ every _____ minutes **Max doses per hour:** _____ (Assess pain every 2 to 4 hours, evaluate the # of attempts vs the # of demand doses received to determine if dose is sufficient)

Cast/ Extremity Assessment		
Hot spots over cast?	☐ No	☐ Yes, describe:
Cast intact:	☐ Yes	☐ No, describe:
Drainage:	☐ None	☐ Yes, describe:
Extremity check		
Color:	☐ WNL	☐ Pale
Temperature:	☐ Warm	☐ Cool
Sensation:	☐ WNL	☐ Loss of sensation
Pain increasing?	☐ No	☐ Yes, describe:
Swelling increasing?	☐ No	☐ Yes, describe:

TYPES OF APHASIA:

- **Dysarthria** – patient has problems with speech due to muscular control.
- **Expressive aphasia (Broca's)** – patient understands, can respond w/ great difficulty in short abbreviated, phrases. Aware and frustrated. Often frontal lobe damage.
- **Receptive aphasia (Wernicke's)** – patient cannot understand spoken and sometimes written words, speaks fluently, long sentences that do not make sense. Patient may not be aware of deficits. Often secondary to L temporal lobe damage.
- **Global or mixed aphasia** – patient has difficulty in understanding and speaking/ communicating. Often secondary to extensive damage of the language areas of the brain.

ASSESSMENT FOLLOW UP:

- ***Notify* the physician of all abnormal findings!!**
- **Use the nursing process to:**
  - **Analyze subjective and objective findings.**
  - **Make a nursing diagnosis.**
  - **Plan and implement appropriate interventions.**
  - **Evaluate the effectiveness of the plan and revise as needed.**

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Putting it All Together

As you walk into the room assess:

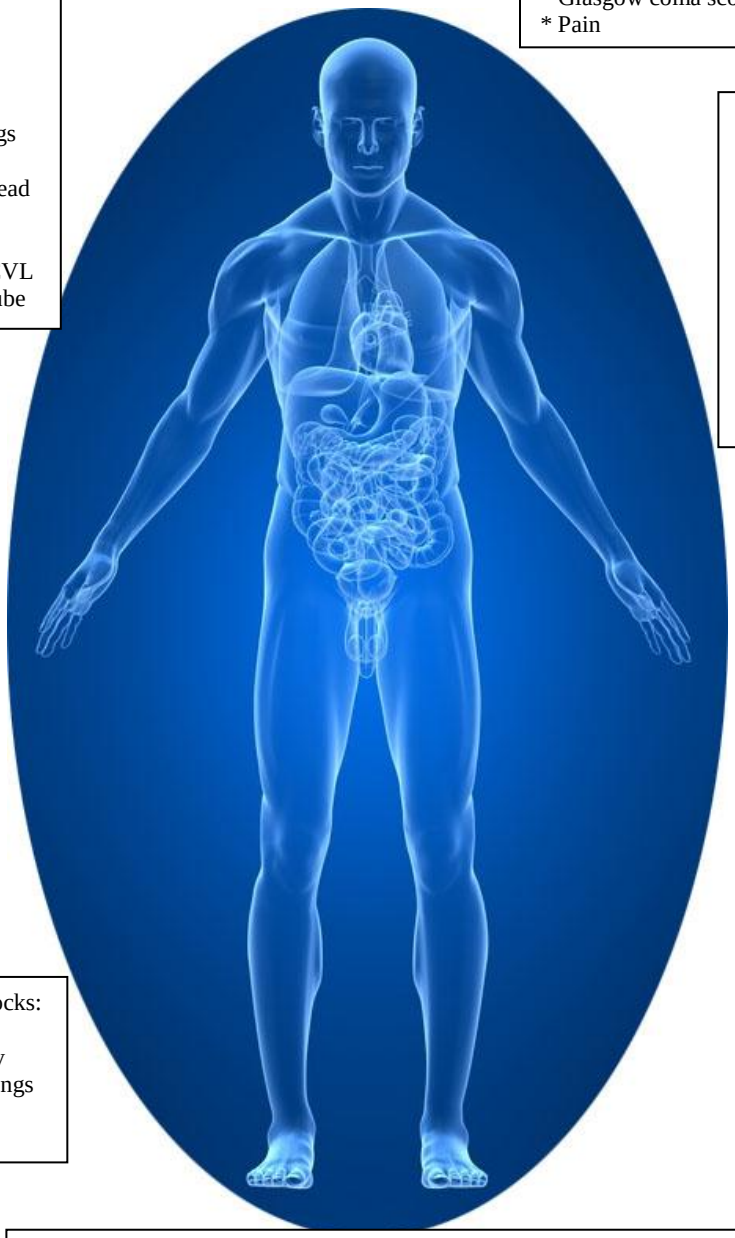
* Awake/ alert, asleep?
* Skin color
* Respiratory effort

As you converse with the patient assess:

* Orientation to person, place, time
* Communication/ speech
* Respiratory effort and rhythm
* On/ off O_2
* Glasgow coma score
* Pain

At the head assess:

* Skin color, temp, moisture and integrity
* Incisions and dressings
* Oral mucosa/ tongue
* Skin tenting on forehead
* Tremors
* Pupils
* Jugular/ subclavian CVL
* NG/ Nasoduodenal tube



At the chest/ back assess:

* Skin color, temp, moisture and integrity
* Incisions and dressings
* Breath sounds
* Respiratory rate, depth, rhythm and effort
* Oxygen settings
* Apical pulse
* Apical/ radial deficit
* Heart sounds

At the upper extremities assess:

* Skin color, temp, moisture and integrity
* Incisions and dressings
* Capillary refill
* Radial pulses
* Skin tenting on forearm
* Edema
* Periph IV/ PICC insertion sites
* Tremors
* Hand grasps
* Muscle tone and strength
* Casts

At the abdomen assess:

* Skin color, temp, moisture and integrity
* Incisions and dressings
* Nutritional intake
* Nausea/ vomiting
* Bowel movements
* Distention/ ascites
* Bowel sounds
* PEG/ J tube site
* Tube feedings
* Stomas
* Continence
* Abdominal/ flank pain
* Bladder distention, s/s of UTI
* Urine output, color, characteristics
* Urinary catheter

At the genitalia/ buttocks:

* Skin color, temp, moisture and integrity
* Incisions and dressings
* Femoral pulses
* Sacral edema

At the lower extremities assess:

* Skin color, temp, moisture and integrity
* Pedal and posterior tibial pulses
* Edema
* Muscle tone and strength
* Incisions and dressings
* Capillary refill
* Tremors
* Casts

* Notify the Physician of abnormal findings of concern
* Implement the nursing process
* Analyze the data
* Identify the appropriate nursing diagnoses.
* Develop and implement a plan
* Evaluate the outcomes

Cardiac Rhythm Assessment by ECG
Sinus rhythm: ☐ Normal sinus rhythm (NSR) [P wave before every QRS, P-R interval < 0.20, rate is between 60 to 100] ☐ Sinus tachycardia [rate => 101] ☐ Sinus bradycardia [rate =< 59] ☐ Sinus arrhythmia [P wave before every QRS, but rate varies with respiration]
Atrial dysrhythmias: ☐ Atrial fib* [atria of heart is fibrillating, ECG shows wavy line, conduct ion thru A-V node to ventricles is erratic] ☐ Atrial flutter with __:1 conduction block [atrial rate approx 300, ventricular (heart) rate 150 = 2:1, HR 75 = 4:1] ☐ Atrial fib/ flutter [atria mixture of flutter and fibrillation] ☐ Paroxysmal supraventricular tachycardia (PSVT) [sudden onset, very fast rates, narrow QRS, P wave absent or behind QRST]
A-V Heart Blocks: ☐ First degree heart block [delayed conduction thru AV node, P-R interval > 0.20] ☐ Second degree A-V block, Mobitz I**[P-R interval lengthens until a QRS is absent, cyclic pattern with every X beat dropped] ☐ Second degree A-V block, Mobitz II*** [P-R interval is stable, no QRS after some P waves due to intermittent AV block] ☐ Third degree A-V block** [no relationship between P waves and QRS complexes due to complete block at AV node]
Paced Rhythms: ☐ Atrial-ventricular (AV) sequential pacing [spike before the P wave and spike before the QRS] 1:1? ☐ Yes ☐ No ☐ Ventricular pacing [pacing spike before the QRS only] 1:1? ☐ Yes ☐ No ☐ Demand pacing [heart rate is higher, pacemaker fires only if there is a delay in spontaneous activity]? ☐ Yes ☐ No ☐ Automatic internal defibrillator (IAD)? ☐ No ☐ Yes Has client felt it fire? ☐ No ☐ Yes, when _____
Ectopic Beats: ☐ Ventricular premature beats (VPB, PVC) [an early, wide QRS, extra beat originating in the ventricle] ☐ Bigeminy [every other beat is a VPB] ☐ Trigeminy [every 3rd beat is a VPB] ☐ Quadrigeminy [every 4th beat is a VPB] ☐ Premature atrial beats (PAB, PAC) [an early, narrow QRS, extra beat originating in the atria, P wave shape may be different] ☐ Premature junctional beats (PJB) [an early, narrow QRS, extra beat originating above the A-V node, no P wave]
Lethal dysrhythmias: ☐ Ventricular escape rhythm (also called idioventricular) [wide QRS complexes, HR @ ventricular intrinsic rate, 30- 40] ☐ Ventricular tachycardia [wide QRS, tachycardic rates, minimal cardiac output due to ineffective pumping, cannot sustain life] ☐ Ventricular fibrillation [erratic line, ventricles are quivering, no pumping action, cardiac output is 0]

*A fib with rapid response (HR > 100) increases myocardial oxygen needs and risk of LV failure is high, also high risk for PE.
**Previously called Wenckebach. ***Mobitz II second degree and third degree block can result in life threatening bradycardia.