Head to Toe Assessment

Initial Assessment

(Patient sitting on the chair)

- Level of consciousness (awake, alert, responsive)
- Alignment
- Skin Color (pink, cyanosis, pale, pallor)
- Affect (Any distress, calm, relaxed)
- Ease of respirations (eupnea, short of breath)
- Hygienic Status including peri-area
- How the patient reports feeling
- Orientation
    1. Person
    2. Place
    3. Time
- Ability to respond to questions (unable to communicate due to dysphasia)
- Glasgow coma scale
- Does the patient report any pain?
    1. What Level? Use your pain scale
    2. Where?
    3. Quality? Use descriptive terms
    4. Frequency?
    5. What makes it better?
    6. What makes it worse?
    7. Any medication taken for pain?
    8. When was the last dose?
- Any equipment or tubes in the room? (Wounds, IV, oxygen, foley catheter, trach, peg tube, feeding pump etc), is it on and working properly?
- Vital signs
    1. Temperature and route
    2. Pulse rate, rhythm, and quality (using pulse scale)
    3. Respiration rate, depth, pattern, and effort
    4. Blood pressure which arm
    5. Oxygen saturation

Head and Neck

- Glasgow coma scale
- Scalp (Infestations? Clean?)
- Skull (bumps, lesions, abrasions)
- Temporal pulses bilaterally (Use pulse scale)
- Ears (difficulty hearing, hearing aid, wax build up)
- Eyes
    1. Pupils equal round reactive to light (PERRL)
    2. Consensual reflex

3. Sclera white
4. Conjunctive pink
5. Ocular movement (6 planes)

- Nose
  1. Patent bilaterally
  2. Drainage (color, consistency)
  3. Mucous membranes
  4. Nasal flaring
- Mouth
  1. Lips pink moist not cracked
  2. Odor?
  3. Teeth present intact? Condition?
  4. Dentures present fit properly
  5. No redness to gums
  6. Mucous membranes moist
  7. Any difficulty swallowing?
- Neck
  1. Trachea Midline
  2. Hypertrophy of thyroid
  3. Carotid Pulse bilaterally (use pulse scale)
  4. Presence of swollen lymph nodes
  5. ROM

Upper Extremities

- Skin Color and temperature bilaterally
- Skin lesions and pressure ulcers bilaterally
- Sensation bilaterally
- Edema bilaterally
- Capillary refill bilaterally(normal refill time is less than 3 seconds)
- Brachial pulse bilaterally (use pulse scale)
- Radial pulse bilaterally (use pulse scale)
- Strength bilaterally
- ROM bilaterally
- Turgor

Chest

- Inspect for equal bilateral movement of the chest wall
- Locate and Auscultate heart valves
  1. Aortic assess S1 and S2
  2. Pulmonic assess S1 and S2
  3. Tricuspid assess S1 and S2
  4. Mitral assess S1 and S2 and count apical pulse for 60 seconds ("Apical rate 74, regular with normal S1 S2")

Back

- Skin color and temperature
- Skin lesions, rash, red blanches and pressure areas
- Inspect and palpate for scoliosis, kyphosis, lordosis of the spine

Lungs

- Auscultate posterior lung sounds
- Auscultate anterior lung sounds
  1. Tracheal
  2. Bronchial
  3. Bronchial vesicular
  4. Vesicular

Musculoskeletal

- Posture
- Gait
- Coordination
- Balance control
- Paralysis
- Amputee status
- Presence of splints, casts, or assistive devices

Height and weight

(Place paper towel to the foot scale), (without shoes)

a) Convert lbs to kilo
b) Convert inches to cm

(Patient lying on the bed)

Neck

- JVD (Once patient is in bed with head of bed elevated no more that 30-45 degrees)

Abdomen

- Inspection
  1. Shape
  2. Size
  3. Distention
  4. Tubes
  5. Color
- Auscultation
  1. Bowel sounds x 4 quadrants
     a) Normal(5 to 30 times a minute)
     b) Hypoactive(long periods of silence)
     c) Hyperactive(very frequent)
     d) Absent (NO sounds heard for 2 to 5 mins)

- Percussion
    1. If distention was noted
    2. Obtain measurement
- Palpation(1/2 to 3/4inch)
    1. All four quadrants
    2. Soft, firm, tender
    3. Pain, grimacing, guarding, abnormal masses, tenderness
- Last bowel movement and continence status
    1. Soft, hard
    2. Brown, black, pale, tarry
    3. Small, large
- Palpate suprapubic area
    1. Distention
    2. Tenderness
    3. Pain
- Continence status
- Urine
    1. Color
    2. Pain
    3. Burning
    4. Frequency/urgency
    5. Foul smell
    6. Amount
- Femoral pulse bilaterally (use pulse scale)

Genitalia/Buttocks

- Redness
- Itching
- Burning
- Skin breakdown/pressure ulcers
- Hemorrholds
- Drainage
- Lesions

Lower Extremities

- Skin color and temperature bilaterally
- Skin lesions and pressure ulcers bilaterally
- Edema bilaterally
- Capillary refill bilaterally
- Strength bilaterally
- ROM bilaterally
- Popliteal pulse bilaterally (use pulse scale)
- Pedal pulse bilaterally (use pulse scale)

- Tibial pulse bilaterally (use pulse scale).
- Sensation bilaterally
- Between toes bilaterally
- Heels bilaterally