HEAD TO TOE ASSESSMENT DOCUMENTATION EXAMPLE

1. **General Appearance**

Observe posture, hygiene, mood, and overall physical condition.

Example: Alert, oriented, well-groomed, no distress.

2. **Vital Signs**

Measure temperature, pulse, respiration rate, blood pressure, and oxygen saturation.

Example: Temp 98.6°F, Pulse 72 bpm 2+, Resp 16/min, BP 120/80 mmHg Left Brachial, O2 Sat 98% on room air.

3. **Head and Neck**

Inspect scalp, hair, and face.

Assess eyes (pupil response, vision), ears (hearing, alignment), nose (patency, mucosa), mouth (teeth, gums, tongue), and throat.

Palpate lymph nodes and thyroid.

Example: Scalp clean, hair evenly distributed. Eyes: PERRLA (pupils equal, round, reactive to light and accommodation), vision intact. No eyewear use. Ears: No discharge, hearing normal. Nose: Mucosa pink, no congestion. Mouth: Teeth intact, mucosa moist. Throat: No redness or swelling. Lymph nodes non-palpable.

4. **Chest and Lungs**

Inspect chest shape and movement.

Auscultate breath sounds.

Assess for symmetry and respiratory effort.

Example: Chest symmetrical, clear breath sounds bilaterally, no wheezing or crackles.

5. **Heart**

Auscultate heart sounds (rate, rhythm, murmurs).

Palpate pulses (radial, brachial, carotid).

Example: Chest symmetrical, clear breath sounds bilaterally, no wheezing or crackles.

6. **Abdomen**

Inspect for distension or scars, color, size.

Auscultate bowel sounds.

Palpate for tenderness or masses.

Example: Soft, non-tender, bowel sounds present in all four quadrants, no masses.

7. **Musculoskeletal**

Assess joint mobility, muscle strength, and gait.

Inspect for deformities or swelling.

Example: Full range of motion to all extremities, muscle strength 5/5, gait steady.

8. **Neurological**

Evaluate orientation, speech, and mental status.

Test reflexes, sensation, and coordination.

Example: Alert and oriented x4(person, place, time, situation), speech clear, follows commands, reflexes normal, sensation intact.

9. **Skin**

Inspect for color, lesions, temperature, and turgor.

Example: Pink, warm, dry, intact, no lesions or rashes.

10. **Extremities**

Check for edema, pulses, and capillary refill.

Assess range of motion and strength.

Example: No edema, capillary refill <3 seconds, pulses palpable, strength equal bilaterally.

PAIN ASSESSMENT EXAMPLE

Please fill out the following pain assessment details:

Patient Name:

Date/Time:

Chief Complaint:

Pain Location:

Pain Intensity (Scale used):

Pain Quality:

Onset:

Duration:

Aggravating Factors:

Relieving Factors:

Associated Symptoms:

Impact on Function:

Intervention Plan:

Reassessment Time:

Example:

Patient Name: John Doe

Date/Time: 19-Nov-2025, 9:30 PM

Chief Complaint: Lower back pain

Assessment Details:

Pain Location: Lower lumbar region

Pain Intensity (NRS 0–10): 7/10

Pain Quality: Sharp, stabbing

Onset: Began 3 days ago after lifting heavy objects

Duration: Constant, worsens with movement

Aggravating Factors: Bending, walking

Relieving Factors: Rest, heat application

Associated Symptoms: Mild stiffness, no numbness or tingling

Impact on Function: Difficulty standing for long periods

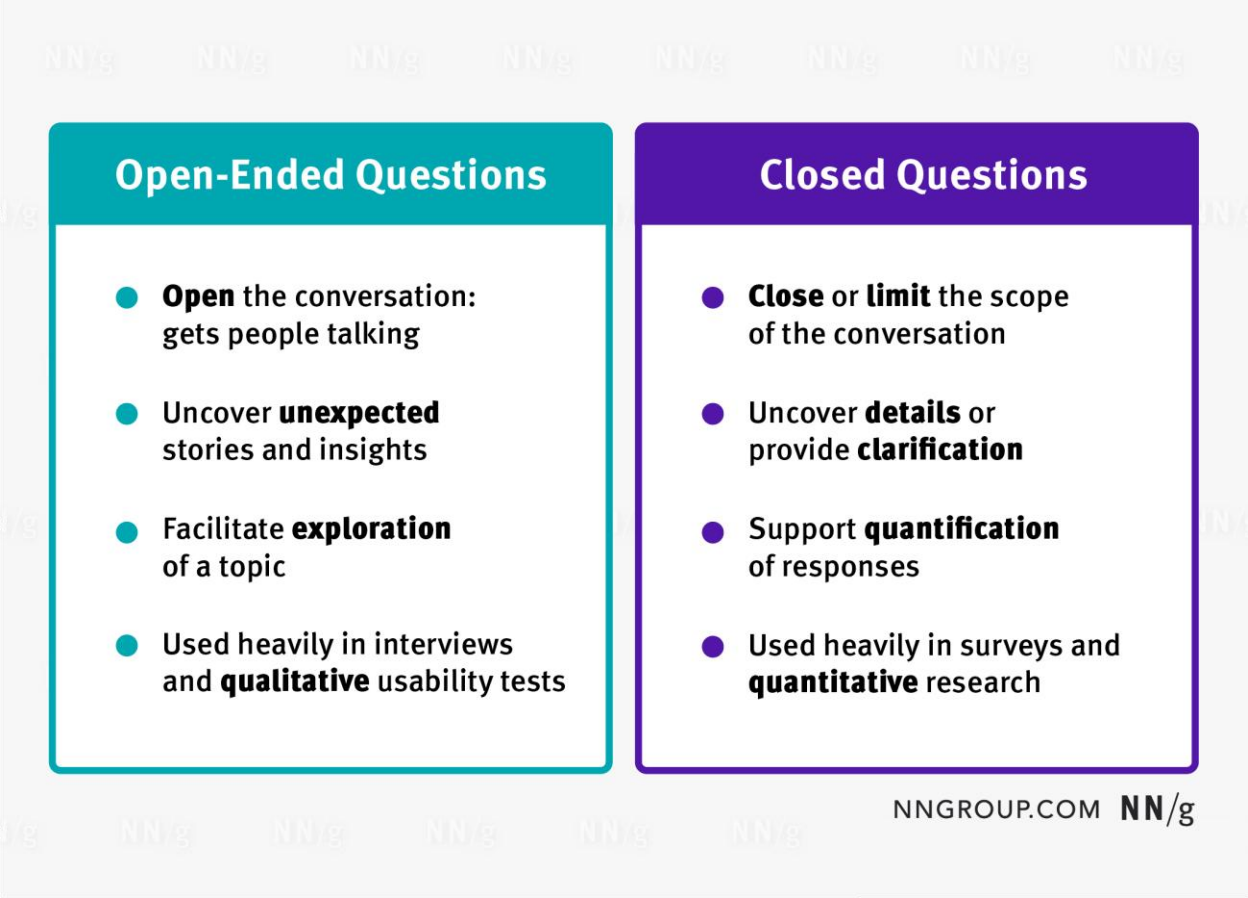
-**Use the numerical pain scale 0/10 or the Wong-Baker FACES pain scale**

OPEN-ENDED QUESTIONS:

- Can you tell me more about your symptoms?" - This encourages patients to elaborate on their condition.
- "What concerns do you have about your treatment?" - This allows patients to express their feelings and worries.
- "How has your condition affected your daily life?" - This helps healthcare providers understand the impact of illness on the patient's life.
- "What are your goals for your health?" - This question encourages patients to think about their health aspirations.
- "Can you describe any changes you've noticed since starting your medication?" - This prompts patient to provide feedback on their treatment.

CLOSED-ENDED QUESTIONS:

- Do you smoke?
- Have you been tested for tuberculosis?
- What year were you born?
- Do you take the medication as directed?
- When did your rash start?



Objective data in nursing:

Vital signs, lab results, physical exam findings

Subjective data in nursing:

Patient-reported symptoms like nausea, anxiety, or pain

Combining both types leads to more accurate diagnoses and personalized care plans.

Objective: A nurse records a patient's blood pressure as 140/90 mmHg.

Subjective: The patient says, “I feel dizzy and anxious.”

Why it matters: Combining both helps clinicians diagnose conditions like hypertension or anxiety disorders more accurately.

Subjective data	Objective data
Difficulty Breathing Chest Pain	Heart rate of 120 beats per minute Respiration rate 30 breaths per minute Excessive sweating Blood pressure 140/80 mm Hg ECG Sinus Tachycardia

Glasgow Coma Scale (GCS)

- **Glasgow Coma Scale**
- The Glasgow Coma Scale provides a score in the range 3-15; patients with scores of 3-8 are usually said to be in a coma. The total score is the sum of the scores in three categories. For adults the scores are as follows:
- **Eye Opening Response**
  - Spontaneous--open with blinking at baseline — 4 points
  - Opens to verbal command, speech, or shout — 3 points
  - Opens to pain, not applied to face — 2 points
  - None — 1 point
- **Verbal Response**
  - Oriented — 5 points
  - Confused conversation, but able to answer questions — 4 points
  - Inappropriate responses, words discernible — 3 points -
  - Incomprehensible speech — 2 points
  - None — 1 point
- **Motor Response**
  - Obeys commands for movement — 6 points
  - Purposeful movement to painful stimulus — 5 points
  - Withdraws from pain — 4 points
  - Abnormal (spastic) flexion, decorticate posture — 3 points
  - Extensor (rigid) response, decerebrate posture — 2 points
  - None — 1 point