

# Head-to-Toe Assessment Checklist

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A head-to-toe physical assessment checklist for nursing students and new nurses, in the order you would perform it at the bedside.

## General Survey and Vital Signs

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- ☐ Perform hand hygiene, introduce yourself and confirm the patient's identity with two identifiers
- ☐ Note general appearance, distress, hygiene, posture and behavior
- ☐ Measure temperature, pulse, respirations, blood pressure and oxygen saturation
  - Count respirations without telling the patient, for example while you still appear to be taking the pulse. People breathe differently when they know they are being watched.
- ☐ Rate pain with a scale the patient understands, and note location, quality and onset
- ☐ Compare vital signs with the last set and the patient's baseline

## Neuro

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- ☐ Assess level of consciousness: alert, lethargic, obtunded or unresponsive
- ☐ Check orientation to person, place, time and situation
- ☐ Check pupils for PERRLA: equal, round, reactive to light and accommodation
- ☐ Check hand grip and foot push strength on both sides
  - Weakness on one side that is new can be a sign of stroke. Report it right away and follow your facility's stroke protocol.
- ☐ Note speech clarity and the ability to follow commands

## HEENT and Neck

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- ☐ Inspect the head and face for symmetry, lesions or injury
- ☐ Inspect the eyes, ears and nose for drainage
- ☐ Inspect the mouth for moist mucous membranes, teeth or dentures and lesions
- ☐ Check that the trachea is midline and look for jugular vein distention

## Respiratory

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- ☐ Inspect breathing pattern, effort, use of accessory muscles and chest shape
- ☐ Auscultate lung sounds front and back, comparing side to side
  - Listen on bare skin, not through a gown. Have the patient breathe slowly through the mouth, and listen to a full breath in each spot.
- ☐ Note adventitious sounds, such as crackles, wheezes, rhonchi or stridor
- ☐ Note cough, sputum color and any oxygen device and flow rate

## Cardiovascular

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- ☐ Auscultate heart sounds at the aortic, pulmonic, Erb's point, tricuspid and mitral areas
- ☐ Count the apical pulse for a full minute if the rhythm is irregular
- ☐ Palpate radial and pedal pulses on both sides and compare strength
- ☐ Check capillary refill and skin color and temperature of hands and feet
- ☐ Check for edema in the feet, ankles and legs and grade it per policy

## Abdomen and GU

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- ☐ Inspect the abdomen for shape, distention, scars and wounds
- ☐ Auscultate bowel sounds in all four quadrants before palpating

Before you chart bowel sounds as absent, follow your facility's rule for how long to listen in each quadrant, which is often several minutes.
- ☐ Lightly palpate for tenderness, firmness or masses, ending with any painful area
- ☐ Ask about last bowel movement, nausea, appetite and diet tolerance
- ☐ Note urine color, amount and any pain or trouble urinating
- ☐ If a urinary catheter is in place, check that it is secured and the bag hangs below the bladder

## Musculoskeletal and Skin

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- ☐ Assess range of motion, muscle strength and gait if safe to walk
- ☐ Inspect skin color, temperature, moisture, turgor and intact areas
- ☐ Check pressure points such as the sacrum, heels and elbows for redness or breakdown

Press on any red area. If it doesn't blanch, it may be an early pressure injury.
- ☐ Score pressure injury risk with the Braden Scale

Braden scores range from 6 to 23. A lower score means higher risk, and 18 or below is a common cutoff for starting prevention steps.

## Safety and Documentation

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- ☐ Complete a fall risk assessment with your facility's tool
- ☐ Inspect IV sites for redness, swelling, pain, leaking and the dressing date
- ☐ Check drains, tubes and wound dressings
- ☐ Make sure the bed is low and locked and the call light is within reach
- ☐ Document findings promptly and report abnormal or changed findings to the nurse or provider