■ HEAD-TO-TOE ASSESSMENT CHECKLIST

11-System Nursing Assessment | Normal Findings | Report Criteria | Documentation Prompts

■ General Appearance & LOC	■ Neurological
■ HEENT	■ Respiratory
❤■ Cardiovascular	■ Gastrointestinal / Abdominal
■ Genitourinary	■ Musculoskeletal
■ Skin & Integumentary	■ Pain Assessment
■ Psychosocial & Safety	

■ Checkboxes	■ Normal Findings	■ Report Criteria	■ Documentation Prompts	■ 11 Systems

■ TIP: Complete your head-to-toe assessment within the first 60 minutes of your shift. Document each system thoroughly. Circle any abnormal findings and notify the provider per your facility protocol.

■ HEAD-TO-TOE ASSESSMENT CHECKLIST

Complete Nursing Assessment • Document All Systems

DATE: _____	**NURSE:** _____	**SHIFT:** ■ Days ■ Nights	**UNIT/ROOM:** _____

PATIENT NAME / MRN: _____ **DOB / AGE:** _____ **PRIMARY DX:** _____

■ GENERAL APPEARANCE & LEVEL OF CONSCIOUSNESS

■ NORMAL ■ ABNORMAL — See notes

- ■ Alert
- ■ Oriented x1
- ■ Oriented x2
- ■ Oriented x3
- ■ Oriented x4
- ■ Follows commands
- ■ GCS ____/15
- ■ No acute distress
- ■ Appropriate affect
- ■ Speech clear

■ Normal Findings

Alert and oriented x4 (person, place, time, event) Appears stated age, NAD (no acute distress) Appropriate affect, cooperative Clean, well-groomed, normal weight for height

■ Report to Provider If:

Altered LOC, confusion, agitation Acute distress, grimacing Extreme weight changes, diaphoresis Mal-nourishment signs

■ DOCUMENTATION PROMPT

Patient is [alert/lethargic/obtunded/comatose], oriented to [person/place/time/event]. Appears [no acute distress/acute distress]. GCS: ___/15.

NOTES:

■ NEUROLOGICAL ASSESSMENT

■ NORMAL ■ ABNORMAL — See notes

- ■ PERRL (pupils 2-4mm)
- ■ Pupils reactive to light
- ■ EOMs intact
- ■ Follows commands
- ■ Strength equal bilateral UE
- ■ Strength equal bilateral LE
- ■ Sensation intact
- ■ No drift noted
- ■ Gait steady (if applicable)
- ■ No seizure activity
- ■ CIWA assessed (if applicable)
- ■ No facial droop

■ Normal Findings

PERRL (pupils equal, round, reactive to light) Strength 5/5 all extremities bilaterally No focal deficits, intact sensation Normal gait and coordination No headache, seizure, or confusion

■ Report to Provider If:

Unequal or non-reactive pupils (emergency) Focal weakness or numbness New confusion or aphasia Seizure activity Sudden severe headache ("thunderclap")

■ DOCUMENTATION PROMPT

Pupils [size]mm, PERRL. Motor strength [5/5 all extremities / deficit noted: ____]. Sensation [intact / impaired: ____]. No focal neurological deficits.

NOTES:

■ HEENT (Head, Eyes, Ears, Nose, Throat)

■ NORMAL ■ ABNORMAL — See notes

- ■ Head: normocephalic, atraumatic
- ■ Eyes: PERRL
- ■ Eyes: no icterus
- ■ Eyes: no discharge
- ■ Ears: no discharge
- ■ Hearing grossly intact
- ■ Nose: no bleeding
- ■ Nasal flaring: absent
- ■ Mucous membranes: moist
- ■ No oropharyngeal lesions
- ■ JVD: absent
- ■ Trachea midline

NOTES:

■ Normal Findings

Head: normocephalic, atraumatic Eyes: PERRL, no icterus, no discharge Ears: no drainage, hearing grossly intact Nose: no bleeding, no nasal flaring Mouth: moist mucous membranes, no lesions

■ Report to Provider If:

Jaundiced sclera (liver disease) Cyanotic mucous membranes (oxygenation) Lesions or exudates in mouth/throat Nasal flaring (respiratory distress) Persistent

■ DOCUMENTATION PROMPT

Head normocephalic, atraumatic. Eyes PERRL, sclera [white/icteric]. Mucous membranes [moist/dry]. Throat [clear/erythema/exudate]. Trachea midline.

■ RESPIRATORY ASSESSMENT

■ NORMAL ■ ABNORMAL — See notes

- ■ RR: ____/min
- ■ Effort: unlabored
- ■ Rhythm: regular
- ■ SpO■: ____% on RA
- ■ Lung sounds: Clear BL
- ■ No wheezing
- ■ No crackles
- ■ No rhonchi
- ■ No stridor
- ■ Chest expansion symmetric
- ■ No accessory muscle use
- ■ No cyanosis
- ■ O■ therapy: ■Y ■N Type/rate: ____
- ■ On vent: ■Y ■N

NOTES:

■ Normal Findings

RR 12–20/min, regular, unlabored Lung sounds clear to auscultation bilaterally SpO■ ≥95% on room air No use of accessory muscles Chest expansion symmetric

■ Report to Provider If:

RR <10 or >24, labored breathing Decreased or absent breath sounds Stridor, wheezing, crackles, rhonchi SpO■ <90% (emergency) Retraction, nasal flaring,

■ DOCUMENTATION PROMPT

RR [rate]/min, [unlabored/labored]. Lung sounds [clear BL / crackles / wheezes / diminished] in [location]. SpO■ [%] on [room air / O■ type and rate].

❤■ CARDIOVASCULAR ASSESSMENT

■ NORMAL ■ ABNORMAL — See notes

- ■ HR: ____bpm
- ■ Rhythm: regular
- ■ BP: ____/____mmHg
- ■ MAP: ____
- ■ S1/S2 present
- ■ No murmur auscultated
- ■ No S3/S4
- ■ Cap refill <3 sec
- ■ Peripheral pulses 2+ bilateral
- ■ No pedal edema
- ■ Extremities warm
- ■ No JVD
- ■ Telemetry: ■Y ■N Rhythm: ____

■ Normal Findings

HR 60–100 bpm, regular rhythm BP within normal limits S1 and S2 heart sounds, no murmur Capillary refill <3 seconds No peripheral edema Pulses 2+ bilaterally

■ Report to Provider If:

HR <50 or >120 (or symptomatic) Hypotension (<90 systolic) or HTN crisis New murmur, S3, S4 gallop Cap refill >3 seconds Edema 3+ or sudden weight gain

■ DOCUMENTATION PROMPT

HR [rate] bpm, [regular/irregular]. BP [systolic/diastolic] mmHg. Heart sounds S1 S2 [regular / murmur: grade __ at ____]. Cap refill [<3 / >3] sec. Extremity pulses [2+ / diminished / absent].

NOTES:	

■ HEAD-TO-TOE ASSESSMENT CHECKLIST

Complete Nursing Assessment • Document All Systems

DATE: _____	**NURSE:** _____	**SHIFT:** ■ Days ■ Nights	**UNIT/ROOM:** _____

PATIENT NAME / MRN: _____ **DOB / AGE:** _____ **PRIMARY DX:** _____

■ GASTROINTESTINAL / ABDOMINAL ASSESSMENT

■ NORMAL ■ ABNORMAL — See notes

- ■ Abdomen: soft
- ■ Non-tender
- ■ Non-distended
- ■ BS present: RUQ RLQ LUQ LLQ
- ■ No guarding
- ■ No rigidity
- ■ No rebound tenderness
- ■ Last BM: ____
- ■ No N/V
- ■ Diet: ____
- ■ NGT: ■Y ■N output: ____
- ■ PEG/G-tube: ■Y ■N
- ■ Ostomy: ■Y ■N output: ____

■ Normal Findings

Abdomen soft, non-tender, non-distended Bowel sounds present x4 quadrants No nausea/vomiting Last BM documented NGT or PEG tube functioning if present

■ Report to Provider If:

Absent bowel sounds (>3-5 min per quad) Board-like rigidity or guarding (peritonitis) Severe distension with pain Bright red blood in stool or emesis

■ DOCUMENTATION PROMPT

Abdomen [soft/firm/distended], [non-tender/tender to palpation at ____]. Bowel sounds [present x4 quadrants / hypo/hyperactive / absent] in [location]. Last BM: [date].

NOTES:

■ GENITOURINARY ASSESSMENT

■ NORMAL ■ ABNORMAL — See notes

- ■ UO: ____mL/hr
- ■ Total UO: ____mL
- ■ Color: clear/yellow
- ■ No foul odor
- ■ No complaints of dysuria
- ■ No hematuria
- ■ No suprapubic tenderness
- ■ Foley: ■Y ■N Date inserted: ____
- ■ Foley: draining well
- ■ External catheter: ■Y ■N
- ■ Dialysis: ■Y ■N Type: ____
- ■ BUN/Creat: ____/____

■ Normal Findings

Adequate urine output (≥0.5 mL/kg/hr) Urine: clear, yellow, no foul odor No complaints of pain/burning with urination No hematuria, no suprapubic tenderness Foley catheter draining if present

■ Report to Provider If:

UO <30 mL/hr for 2+ hours (notify provider) Dark, cloudy, or foul-smelling urine Hematuria or bright red blood in urine Suprapubic tenderness or distension

■ DOCUMENTATION PROMPT

Urine output [amount] mL/hr, [clear yellow / hematuria / cloudy]. Foley catheter [present, draining without difficulty / not present]. No bladder distension palpated.

NOTES:

■ MUSCULOSKELETAL ASSESSMENT

■ NORMAL ■ ABNORMAL — See notes

■ ROM: full UE bilateral

■ ROM: full LE bilateral

■ Strength UE 5/5 bilateral

■ Strength LE 5/5 bilateral

■ Ambulation status: ____

■ Gait steady

■ No joint swelling

■ No deformity

■ No crepitus

■ No bone pain

■ Cast/splint: ■Y ■N Neurovascular check: ____

■ Fall risk score: ____ Interventions in place: ■Y ■N

■ Normal Findings

Full ROM all joints (or baseline) Strength 5/5 all extremities Ambulates independently or at baseline No joint swelling, warmth, or deformity No complaints of bone or joint pain

■ Report to Provider If:

Acute loss of strength or ROM New joint swelling, redness, warmth Bone deformity or crepitus Inability to bear weight Compartment syndrome signs (5 Ps)

■ DOCUMENTATION PROMPT

Upper extremities: [strength, ROM]. Lower extremities: [strength, ROM]. Gait [steady / unsteady]. Ambulation [independent / with assist / non-ambulatory]. Fall precautions [in place / not applicable].

NOTES:

■ SKIN & INTEGUMENTARY ASSESSMENT

■ NORMAL ■ ABNORMAL — See notes

■ Skin: warm

■ Skin: dry

■ Skin: intact

■ No lesions or rashes

■ No cyanosis

■ No pallor

■ No jaundice

■ No diaphoresis

■ Braden Scale: ____

■ No pressure injuries

■ Wound: ■Y ■N Location: ____

■ IV site(s): no erythema/edema

■ Central line site: intact

■ Incision: intact / staples / sutures / NWPT

■ Normal Findings

Skin warm, dry, intact, no lesions Color consistent with patient baseline No rashes, bruising, or breakdown Surgical sites/wounds: healing, no s/s infection IV sites: no erythema, edema, or tenderness

■ Report to Provider If:

Skin breakdown or pressure injury present Diaphoresis (unexplained) Jaundice, cyanosis, pallor Rash or petechiae Wound infection signs: erythema, purulent

■ DOCUMENTATION PROMPT

Skin [warm/cool], [dry/diaphoretic], [intact / wound noted at ____]. Color [baseline / pallor / jaundice / cyanosis]. IV site(s) [without erythema or edema / erythema noted at ____]. Braden Scale: [score].

NOTES:

■ PAIN ASSESSMENT

■ NORMAL ■ ABNORMAL — See notes

■ Pain scale used: ■NRS ■FACES ■CPOT ■FLACC

■ Pain score at assessment: ____/10

■ Location: ____

■ Quality: ache/sharp/burning/throbbing

■ Onset: ____

■ Duration: ____

■ Radiation: ■Y ■N to: ____

■ Aggravating factors: ____

■ Relieving factors: ____

■ Interventions given: ____

■ Reassessment score (30–60 min post): ____/10

■ Goal pain score: ____/10

■ Normal Findings

Patient reports pain 0/10 or manageable pain Pain is controlled with current regimen No grimacing, guarding, or non-verbal pain indicators Patient verbalized understanding of pain scale ADLs not limited by pain

■ Report to Provider If:

Uncontrolled pain >7/10 after interventions New or unexpected pain location/quality Non-verbal patient with CPOT score >2 Pain unresponsive to

■ DOCUMENTATION PROMPT

Patient reports pain [score/10] at [location]. Quality: [descriptor]. Interventions provided: [medication/non-pharm]. Reassessment [score/10] at [time]. Patient [states pain tolerable / reports inadequate relief].

NOTES:

■ PSYCHOSOCIAL & SAFETY ASSESSMENT

■ NORMAL ■ ABNORMAL — See notes

- ■ Mood: appropriate
- ■ Affect: congruent
- ■ No anxiety expressed
- ■ No depression signs
- ■ Support system identified
- ■ Understands plan of care: ■Y ■N
- ■ Safety screen completed: ■Y ■N
- ■ No suicidal ideation
- ■ No homicidal ideation
- ■ Delirium screen (CAM): ■Negative ■Positive
- ■ CIWA/COWS completed if applicable
- ■ Substance use history reviewed
- ■ Social work consult: ■Y ■N

■ Normal Findings

Appropriate mood and affect No signs of anxiety or depression Adequate support system Understands and agrees with plan of care No safety concerns Coping mechanisms intact

■ Report to Provider If:

Expressed suicidal or homicidal ideation Extreme anxiety or agitation Acute psychosis or delirium Verbal or physical aggression Denies illness/refuses

■ DOCUMENTATION PROMPT

Patient presents with [appropriate/anxious/depressed/agitated] mood and [congruent] affect. Delirium screen [negative/positive]. No [suicidal/homicidal] ideation expressed. Support system [present/absent].

NOTES:	

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