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Head-To-Toe Assessment		Date:
NAME: _____		VITAL SIGNS Temp: _____ Pulse: _____ RR: _____ BP: _____ SpO2: _____
AGE: _____ SEX: _____ ROOM: _____		
Admit Date: _____		
Allergies: _____		
LEVEL OF CONSCIOUSNESS ☐ AWAKE ☐ RESTLESS ☐ ALERT ☐ CONFUSED ☐ DROWSY ☐ SEDATED		Pain ☐ Yes ☐ No Location: _____ Rating 1-10: _____ Quality: _____ Duration: _____
ORIENTATION ☐ Person ☐ Place ☐ Time ☐ Situation		MENTAL STATUS ☐ Calm ☐ Pleasant ☐ Cooperative ☐ Anxious ☐ Uncooperative ☐ Angry ☐ Restless ☐ Withdrawn
HEAD, FACE, HEAR HEAD: _____ FACE: _____ HEAR: _____		

HEAD TO TOE ASSESSMENT

ABDOMEN		
Inspection ☐ Symmetrical ☐ Rounded ☐ Other: _____	Bowel Sounds ☐ RLQ: Active / Hyperactive / Absent ☐ RUQ: Active / Hyperactive / Absent ☐ LUQ: Active / Hyperactive / Absent ☐ LLQ: Active / Hyperactive / Absent	Palpation ☐ Soft ☐ Tender ☐ Firm ☐ Hard ☐ Guarding Pain ☐ Flat ☐ Rigid ☐ Distended
SKIN ☐ Temperature: Hot / Warm / Cool / Cold ☐ Moisture: Clammy / Diaphoretic / Dry ☐ Turgor: Elastic / Tenting / Edema ☐ Color: _____ ☐ Pressure Ulcers: _____ ☐ Wound: _____	UPPER EXTREMITIES ☐ Shoulder Strength: Strong / Weak / Unable ☐ Grip Strength: _____ ☐ Range of Motion: _____ ☐ Capillary Refill: _____ ☐ Radial Pulse: _____	LOWER EXTREMITIES ☐ Pedal Pulse: Strong / Weak / Unable ☐ Range of Motion: _____ ☐ Capillary Refill: _____ ☐ Edema: _____ ☐ Dorsalis Pedis Pulse: _____ ☐ Posterior Tibial Pulse: _____



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**Kim Cooper, RN, MSN, Kelly Gosnell,
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