

Head to Toe Assessment Checklist

Checklist · 97 items · 15 sections

A complete nursing head-to-toe assessment, organized top-down by body system. Follows the standard order taught in Jarvis, Bates, and most US nursing programs, with the exam techniques in the order they should actually be performed (auscultate the abdomen before palpating).

Open the editable, AI-powered version online:

<https://genechecklist.com/checklist/head-to-toe-assessment-checklist>

GENERAL SURVEY AND VITALS

- Observe overall appearance: stated age vs. apparent age, distress level, hygiene, grooming, posture
HIGH
- Note body habitus, positioning, and any obvious deformities or asymmetry
HIGH
- Assess level of consciousness (LOC): alert, drowsy, lethargic, obtunded, stuporous, or unresponsive
HIGH
- Document orientation x4 (AOx4): person, place, time, situation
HIGH
- Measure temperature; note route (oral, tympanic, temporal, axillary, rectal)
HIGH
- Assess pulse: rate, rhythm, quality (apical for 1 full minute if irregular)
HIGH
- Count respiratory rate for 1 full minute; note rhythm, depth, and effort
HIGH
- Measure blood pressure in correct cuff size; note position and arm used
HIGH
- Obtain SpO₂; document on room air or supplemental O₂ with liter flow
HIGH
- Assess pain using an age-appropriate scale (0-10, FACES, FLACC, PAINAD): location, quality, radiation, timing, alleviating/aggravating factors
HIGH
- Record height, weight, BMI; note recent weight changes
- Review allergies, code status, and isolation precautions before contact

NEUROLOGICAL

- Assess Glasgow Coma Scale (GCS): eye opening, verbal response, motor response (score 3-15)
HIGH
- Evaluate pupils for PERLLA: pupils equal, round, reactive to light and accommodation; document size in mm
HIGH
- Screen cranial nerves as indicated (smell, vision, EOMs, facial sensation and symmetry, hearing, swallowing, shoulder shrug, tongue protrusion)
HIGH
- Test motor strength bilaterally in upper and lower extremities; grade 0/5 to 5/5
HIGH
- Assess sensation to light touch in all four extremities; compare bilaterally
- Test deep tendon reflexes (biceps, triceps, patellar, Achilles); grade 0 to 4+
- Evaluate coordination: finger-to-nose, heel-to-shin, rapid alternating movements
- Perform Romberg test for balance if patient is ambulatory
- Observe gait: steadiness, symmetry, assistive devices, fall risk
HIGH
- Note speech: clarity, fluency, appropriateness; assess for slurring or aphasia

HEAD AND FACE

- Inspect skull and scalp for symmetry, lesions, masses, lice, tenderness
- Assess hair distribution, texture, cleanliness
- Inspect face for symmetry at rest and with movement (smile, frown, raise eyebrows)
- Palpate temporal arteries for tenderness or thickening
- Assess jaw ROM and TMJ for crepitus or pain

EYES

- Inspect external eye structures, lids, lashes, lacrimal apparatus
- Assess conjunctiva (pink) and sclera (white, anicteric)
- Test visual acuity with Snellen or near-vision card; note corrective lenses
- Assess extraocular movements (EOMs) through six cardinal fields of gaze
- Test peripheral visual fields by confrontation
- Perform fundoscopic exam if indicated and within scope

EARS, NOSE, MOUTH, THROAT

- Inspect external ears for symmetry, lesions, drainage, hearing aids
- Screen hearing using whisper test or finger rub bilaterally
- Inspect nares for patency, drainage, septal deviation, flaring
- Palpate frontal and maxillary sinuses for tenderness
- Inspect lips, oral mucosa, gums, teeth, tongue for color, moisture, lesions, dentition
- Assess uvula midline rise with 'ahh'; inspect tonsils and pharynx
- Palpate cervical, preauricular, postauricular, submandibular, supraclavicular lymph nodes

NECK

- Assess neck ROM: flexion, extension, lateral rotation, lateral flexion
- Confirm trachea is midline
- HIGH**
- Palpate thyroid for size, symmetry, nodules, tenderness
- Inspect for jugular venous distention (JVD) with HOB at 30-45°
- HIGH**
- Auscultate carotid arteries for bruits BEFORE palpating; never palpate both carotids simultaneously

RESPIRATORY AND CHEST

- Inspect chest shape, symmetry, AP-to-lateral diameter, accessory muscle use, retractions
- HIGH**
- Note respiratory pattern: regular, Cheyne-Stokes, Kussmaul, Biot's, apneic episodes
- HIGH**
- Palpate chest for tenderness, crepitus, symmetric expansion
- Percuss posterior lung fields: resonant, dull, hyperresonant
- Auscultate breath sounds in all lobes, anterior and posterior: vesicular, bronchial, bronchovesicular
- HIGH**
- Document adventitious sounds: crackles (fine/coarse), wheezes, rhonchi, stridor, pleural friction rub
- HIGH**
- Reconfirm SpO2 and O2 delivery device, flow rate, FiO2 if applicable
- HIGH**

CARDIOVASCULAR

- Auscultate apical heart rate at 5th ICS, midclavicular line, for 1 full minute
HIGH
- Identify S1 and S2; note any S3, S4, murmurs, clicks, or rubs
HIGH
- Note heart rhythm: regular, irregularly irregular, regularly irregular
HIGH
- Palpate peripheral pulses bilaterally: radial, brachial, femoral, popliteal, dorsalis pedis, posterior tibial; grade 0-4+
HIGH
- Assess capillary refill in fingers and toes (<3 seconds is normal)
HIGH
- Inspect for peripheral edema; grade 1+ to 4+, note pitting vs. non-pitting
HIGH
- Reassess for JVD and hepatjugular reflux if heart failure suspected

ABDOMEN

- Inspect abdomen for contour, symmetry, scars, distention, striae, hernias, pulsations
HIGH
- Auscultate bowel sounds in all 4 quadrants BEFORE palpation; note normo/hypo/hyperactive or absent
HIGH
- Auscultate for vascular bruits over aorta, renal, iliac, femoral arteries
- Percuss all 4 quadrants for tympany and dullness; estimate liver span
- Palpate lightly in all 4 quadrants for tenderness, guarding, rigidity
HIGH
- Palpate deeply for masses, organomegaly; defer if acute abdomen suspected
- Assess rebound tenderness, Murphy's sign, McBurney's point, CVA tenderness as indicated
- Palpate suprapubic area for bladder distention; review last void

MUSCULOSKELETAL

- Inspect extremities for symmetry, deformities, atrophy, swelling
- Assess active and passive ROM of major joints; note crepitus or limitation
- Test muscle strength bilaterally in upper and lower extremities; grade 0/5 to 5/5
HIGH

Observe posture and spinal alignment; inspect for kyphosis, scoliosis, lordosis

Evaluate gait, balance, assistive devices; document fall risk score

HIGH

SKIN, HAIR, NAILS

Inspect skin color: pink, pale, cyanotic, jaundiced, mottled, flushed

HIGH

Assess skin temperature, moisture, turgor

HIGH

Document lesions, rashes, bruises, wounds, surgical incisions: size, location, drainage, stage

HIGH

Inspect pressure points (sacrum, heels, occiput, elbows, ischial tuberosities); complete Braden Scale

HIGH

Inspect nails for color, capillary refill, clubbing, shape, hygiene

GENITOURINARY

Review voiding pattern: frequency, urgency, dysuria, hesitancy, nocturia

Inspect urine for color, clarity, odor, approximate volume

If indwelling catheter present: document type, size, securement, insertion date, patency

Inspect perineal skin for integrity, irritation, breakdown

Assess for incontinence and skin barrier protection

LOWER EXTREMITIES

Reassess pedal pulses (dorsalis pedis, posterior tibial), color, temperature bilaterally

HIGH

Check for edema, calf tenderness, warmth, or asymmetry; consider DVT risk

HIGH

Evaluate sensation and motor function in feet; note neuropathy

Inspect feet, toes, toenails for wounds, ulcers, pressure injuries

Confirm SCDs or TED hose are in place and functioning if ordered

PSYCHOSOCIAL AND MENTAL STATUS

Assess mood and affect: appropriate, flat, anxious, tearful, agitated

Evaluate thought process: logical, coherent, tangential, disorganized

Screen for safety: suicidal or homicidal ideation per facility protocol

- Identify support system, primary caregiver, cultural and spiritual considerations
- Review coping, recent stressors, learning needs for discharge planning

LINES, TUBES, DRAINS, SAFETY

- Inspect all IV sites for patency, redness, swelling, infiltration, phlebitis; verify date and dressing
HIGH
- Verify continuous infusions: medication, rate, line labeling, pump settings
HIGH
- Assess all tubes and drains (NG, OG, chest tube, JP, Foley, PEG): patency, securement, output volume, character
HIGH
- Confirm safety: bed in lowest position, brakes locked, call light within reach, side rails per policy, ID band on
HIGH
- Document O2 delivery, suction setup, telemetry leads, and any restraints with order and checks