		Score
1a. Level of Consciousness: **Cerebrum** [Assess Alertness] What does it take to arouse the patient?	0 = Alert; Keenly responsive 1 = Not alert; Drowsy, arouses by minor stimulation 2 = Not alert; Obtunded requires repeated stimulation 3 = Unresponsive (flaccid) or responds only with motor reflexes	
1b. LOC Questions: **Cerebrum** • How old are you? (Age) • What month is it? (Date)	0 = Answers both questions correctly 1 = Answers only one question correctly 2 = Answers neither question correctly	
1c. LOC Commands: **Cerebrum** • Close – Open eyes ("hard") • Make a fist	0 = Performs both tasks correctly 1 = Performs one task correctly 2 = Performs neither task correctly	
2. Best Gaze: (Head Stationary) **CN 3 & 6** Eyes follow finger? (L→R) [Horizontal Only]	0 = Normal 1 = Partial gaze palsy; [Abnormal tracking in one or both eyes] 2 = Forced deviation; [Total gaze paresis]	
3. Visual Fields: (4 - With eyes forward) **CN 2** Assess ability to see different numbers of fingers in all 4 visual quadrants, by wiggling fingers in periphery (Assess each eye, one at a time)	0 = No visual loss  1 = Partial Hemianopsia  2 = Complete Hemianopsia  3 = Bilateral Hemianopsia  (in Both eyes)	
4. Facial Palsy **CN 7 & Motor** • Show me your teeth (smile) • Raise eyebrows • Squeeze eyes shut / open	0 = Normal symmetrical movements 1 = Minor paralysis- asymmetry on smiling 2 = Partial paralysis-total or near total paralysis lower face 3 = Complete paralysis of one or both sides (no movement upper or lower)	
5. Arms: **Motor** Ask patient hold out arms, palms up for <u>10 count</u> • 5a. Left arm (Watch for drift) • 5b. Right arm (Watch for drift)	0 = No drift 1 = Drifts down before 10 seconds (does not hit bed) 2 = Falls to bed before 10 seconds 3 = No effort against gravity; falls immediately 4 = No movement [UN = Amputation or joint fusion. Explain: _____	R L
6. Legs: **Motor** Ask patient to lift leg (30°) off bed for <u>5 count</u> • 6a. Left leg • 6b. Right leg	0 = No drift; leg holds 30° position for full 5 seconds 1 = Drifts before the end of the 5 seconds (but does not hit bed) 2 = Falls, hits bed before the end of the 5 seconds 3 = Falls to bed immediately 4 = No movement	R L
7. Limb Ataxia: **Cerebellum** • Patient finger →nose→examiner finger • Heel → knee-slide down shin, then up shin (both legs)	0 = Absent 1 = Present in one limb 2 = Present in two limbs UN = Amputation or joint fusion. Explain: _____	
8. Sensory: (Use Paperclip) **Sensory** Sharp touch bilaterally (L←→R, & Both) to arm, leg, & face (Sharp / Dull?) (Feel same: L? / R?)	0 = Normal; No sensory loss 1 = Mild to moderate sensory (What is sharp on one side feels dull on the other) 2 = Severe to total sensory loss (Patient is not aware of being touched)	
9. Best Language: **Cerebrum** Describe the events in the situation picture Name the objects in the item picture Read sentences on the sentence page	0 = No aphasia 1 = Mild to moderate aphasia 2 = Severe aphasia; All communication is fragmentary 3 = Mute, global aphasia   You know how Down to earth Home from work	
10. Dysarthria: (Speech Motor Skills) **CN 5 , 7 , 9, 10 & 12** Read list: Mama, Tip-Top, Fifty-fifty, Thanks, Huckleberry, …	0 = Normal 1 = Mild to moderate; Slurs some words but can be understood 2 = Severe; Slurred / unintelligible or is mute / anarthric UN = Intubated or other physical barrier. Explain: _____ **Aphasia** – Impaired cognitive ability (**Speaking Greek**) **Dysarthria** – Impaired motor ability to speak (**Drunk Sailor**)	
11. Extinction and Inattention: **Sensory** With <u>eyes closed</u>, identify where touched (L, R, or both?) or with eyes open, sees wiggling fingers in periphery (L, R, or both?)	0 = No abnormality 1 = Partial neglect: Visual, tactile, auditory, spatial, or personal inattention 2 = Profound neglect: Hemi-inattention or extinction to more than one modality	

NIHSS Difficult Presentation Assessment Tip Sheet

Scale Item	Coma	Intubated/Confused	Tips to Test
1a- Responsiveness	2-For some movement 3-Flaccid/No movement	0- If awake and alert 2- Some purposeful movement	-Not a verbal test: Can be assessed quickly during introduction- Do they respond at all??
1b- Questions	2	1- ET tube or severe facial trauma 2- Patient doesn't understand	-If pt. quickly corrects themselves= score as correct -pt. may write answers, spelling doesn't matter
1c- Commands	2	2- If unable to understand commands	-Do NOT assess weak side or pantomime for severe aphasia If unable to perform, provide simple commands, use any 2 simple 1 step commands pt. can do
2- Best Gaze	Assess Oculocephalic Reflex (Doll's Eyes)- hold eyes open- turn side to side	0- If pt. can track your movements Assess Oculocephalic Reflex (Doll's Eyes) if not following commands or if they are Blind.	-MUST be assessed on ALL pts. -if pt. is confused, move around room talking to pt. and see if they can track your movements
3- Visual	0-Blinks to visual threat 3- If no blink to visual threat or Blind d/t any cause	If pt. does not understand (use visual threat) 1- Clear extinction to one side 3- No blinking in ANY field or Blind d/t any cause	-3 ways: finger counting, finger movement, or visual threat -Test all 4 quadrants of each eye separately -Allow pt. To wear glasses!
4- Facial Palsy	3	Assess facial movement while talking. If non-verbal/confused assess grimace w/noxious stimuli	-Pt. should wear dentures during exam -Remove facial bandages, ET tape, etc. if possible
5/6- Motor Arm/Leg	Use noxious stimuli 3- Withdraws 4- No movement at all	-If pt. doesn't follow commands use observation -Use pantomime -Will the limbs withdraw from pain?	-UN only for joint fusion or amputation shoulder/hip -If obvious neglect, place arm/leg in non-effected visual field and encourage pt. to hold limb up
7- Ataxia	0	0-Unable to understand or paralyzed -If Blind have pt. extend arms, then take finger to nose	-Keep extremities in working visual field -Not an assessment of gait -UN only with joint fusion or amputation
8- Sensory	2	-Use pinprick to observe reaction if pt. is unable to cooperate -Aphasia normally scores 0 or 1 as it must be clear cut there is no feeling	-Do not ask sharper/duller. Ask "can you feel me touch on both sides?" "Is it same or different b/n two sides?" Use multiple locations (face, arms, legs) Avoid hands and feet
9- Best Language	3	If intubated, ask pt. to write responses 2-Listener carries burden of conversation 3-Garbled or mute AND not following commands	-Blind: describe objects placed in their hand -Pts. may call objects different things in different regions of the country so use best judgement. Ex: glove=hand; feather=leaf; cactus=cartoon
10- Dysarthria	2	UN- ET tube Severe aphasia assesses spontaneous speech	-Blind or unable to read, have pt. repeat words/sentences (try to use standard words)
11-Extinction	2	Score only if present	ALWAYS testable- pay specific attention to 2, 3 & 8

TriHealth Neuroscience Institute

NIH Stroke Scale – Word List

MAMA

TIP-TOP

FIFTY-FIFTY

THANKS

HUCKLEBERRY

BASEBALL PLAYER

NIH Stroke Scale – Sentences

You know how.

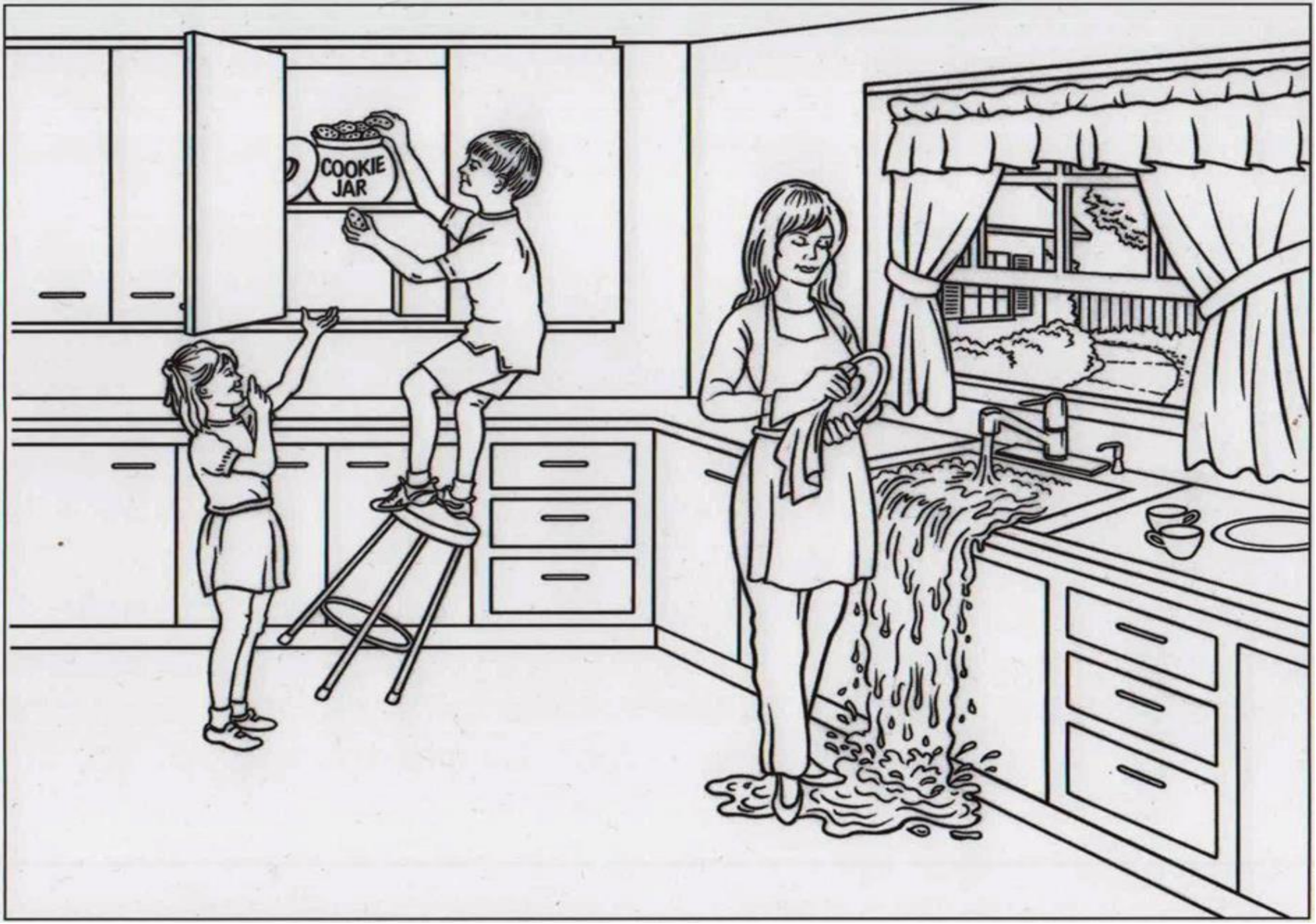
Down to earth.

I got home from work.

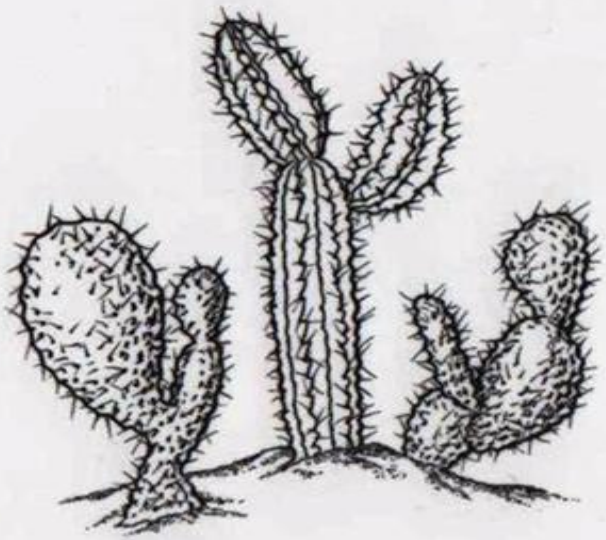
Near the table in the dining room.

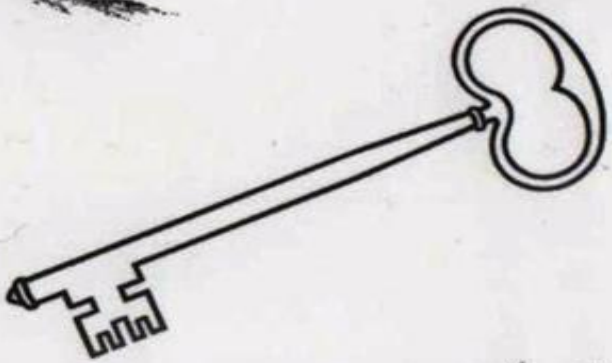
They heard him speak on the radio last night.

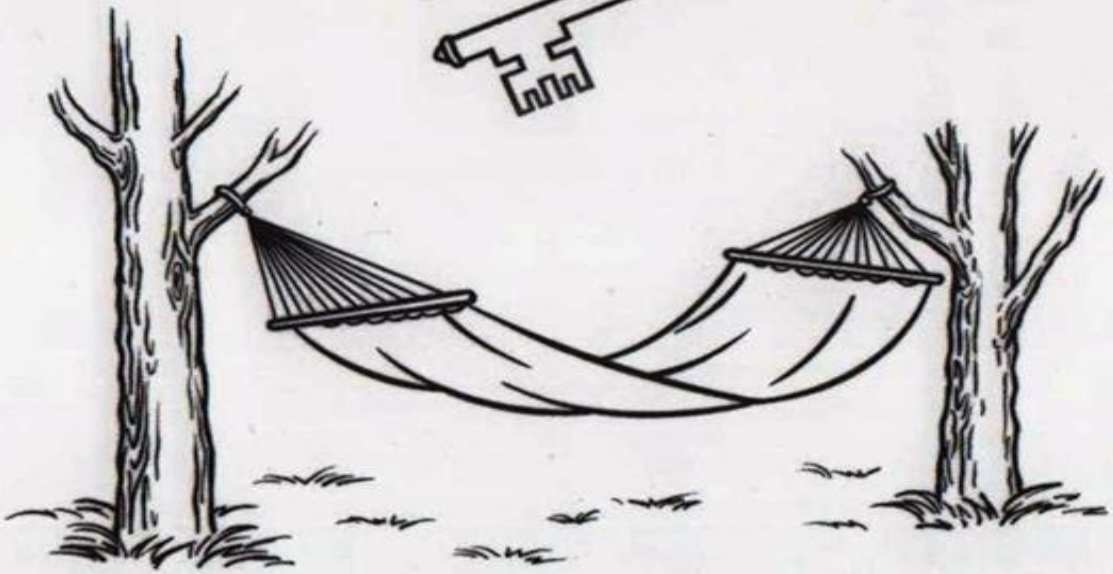
NIH Stroke Scale – Picture Description



NIH Stroke Scale – Naming List







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