NIHSS Checklist

The National Institutes of Health Stroke Scale (NIHSS) is a standardized tool for assessing the severity of neurological deficits in suspected ischemic stroke. Practitioners who are documenting an NIHSS score should have completed a *certification program* (available for free online). The steps of the NIHSS are summarized here, adapted from the *Canadian Best Stroke Practices pocket card* (also available online).

- ☐ Wash your hands
- ☐ Introduce yourself to the patient
- ☐ Drape patient appropriately
- ☐ Set of vitals

Scale Component	*Scoring*
1a. Level of consciousness ☐ Ask a brief question such as "are you comfortable?" or "do you have any pain?"	0 = Alert 1 = Not alert, rousable with minimal stimulation 2 = Not alert, requires repeated stimulation 3 = Not rousable
1b. LOC Questions ☐ "What month is it?" ☐ "How old are you?" *Score only first attempt, do not coach	0 = Answers both correctly 1 = Answers one correctly 2 = Answers both incorrectly
1c. LOC Commands ☐ "Open and close your eyes" ☐ "Grip and release your hand" *Score only first attempt; do not coach	0 = Does both correctly 1 = Does one correctly 2 = Does neither correctly
2. Best gaze ☐ Ask patient to follow finger, moving to left and right to assess horizontal gaze *If unable to follow commands, move your face while maintaining eye contact	0 = Normal 1 = Partial gaze palsy 2 = Forced deviation or total gaze paresis (i.e. NOT overcome by oculocephalic maneuver)
3. Visual fields ☐ Use number of fingers, finger movement, or visual threat to check upper and lower lateral quadrants of visual fields	0 = No visual loss 1 = Partial hemianopsia 2 = Complete hemianopsia 3 = Bilateral hemianopsia
4. Facial palsy ☐ "Show me your teeth" ☐ "Raise your eyebrows" ☐ "Shut your eyes tight" *Ask and demonstrate	0 = Normal symmetrical movement 1 = Minor paralysis (flattened nasolabial fold, asymmetry on smiling) 2 = Partial paralysis (lower face) 3 = Complete paralysis
5. Arm motor ☐ Ask patient to extend one arm with palms down to 90° if seated, 45° if supine, and hold for 10 seconds ☐ Repeat with opposite arm *Score each limb separately	0 = No drift 1= Drift (i.e. falls before 10 seconds) 2 = Some effort vs gravity 3 = No effort vs gravity 4 = No movement UN = Amputation or joint fusion

Adapted from Heart & Stroke Foundation. "Canadian Best Stroke Practices: Stroke Assessment and Prevention Pocket Cards." Accessed November 6, 2017. Available at http://www.strokebestpractices.ca/resources/.

Scale Component	*Scoring*
6. Leg motor ☐ Ask supine patient to lift one leg to 30° and hold for 5 seconds ☐ Repeat with opposite leg *Score each limb separately	0 = No drift 1= Drift (i.e. falls before 5 seconds) 2 = Some effort vs gravity 3 = No effort vs gravity 4 = No movement UN = Amputation or joint fusion
7. Limb ataxia ☐ "Touch your finger to your nose" ☐ "Touch your heel to your shin" ☐ Repeat both on opposite side	0 = Absent 1 = Present in one limb 2 = Present in two or more limbs UN = Amputation or joint fusion
8. Sensory ☐ Have patient close eyes and tell you if they can feel pinprick on arms (not hands), legs (not feet), trunk, and face *If decreased LOC, use noxious stimulus	0 = Normal 1 = Mild-to-moderate sensory loss 2 = Severe-to-total sensory loss *Stuporous/aphasic → 0 or 1 *Quadiplegic /comatose patients → 2
9. Best language ☐ "Describe what you see in this picture" ☐ "Read out these sentences" ☐ "Name the items in this picture" *See next page for reference	0 = No aphasia 1 = Mild-to-moderate aphasia 2 = Severe aphasia 3 = Mute, global aphasia *Intubated patients should be asked to write *Comatose patients → 3
10. Dysarthria ☐ "Read these words" (see next page) *If visually impaired, ask to repeat words	0 = Normal articulation 1 = Mild-to-moderate dysarthria 2 = Severe dysarthria UN = Intubated or other physical barrier
11. Extinction and Inattention ☐ Ask patient to close eyes ☐ "Tell me on which side you hear the sound" while rubbing fingers together near one ear, then the other, then both ☐ "Tell me on which side you feel my touch" while touching one side of face/body, then the other, then both ☐ Ask patient to look at your nose and then "tell me on which side you see my fingers moving" while moving fingers on the far right of their visual field, then the far left, then both *Latter two steps can be incorporated into VF and sensory testing above	0 = No abnormality 1 = Visual, tactile, auditory, spatial, or personal inattention 2 = Profound hemi-inattention or extinction to more than one modality *Severe vision loss preventing visual double simultaneous stimulation, but no other evidence of extinction/inattention → 0
	The NIHSS is scored out of **42** *Score of <4 is associated with good outcome

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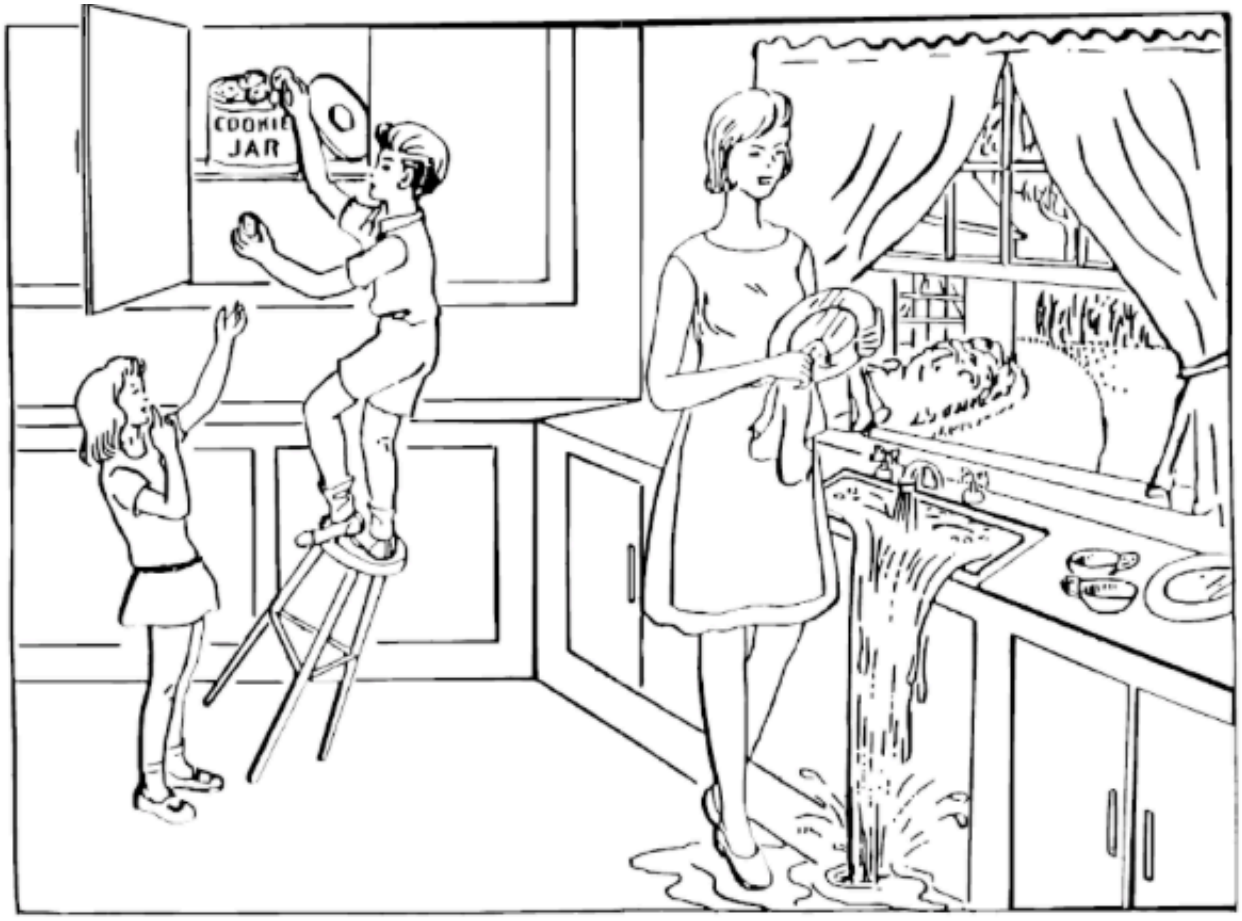

You know how.

Down to earth.

I got home from work.

Near the table in the dining room.

They heard him speak on the radio last night.

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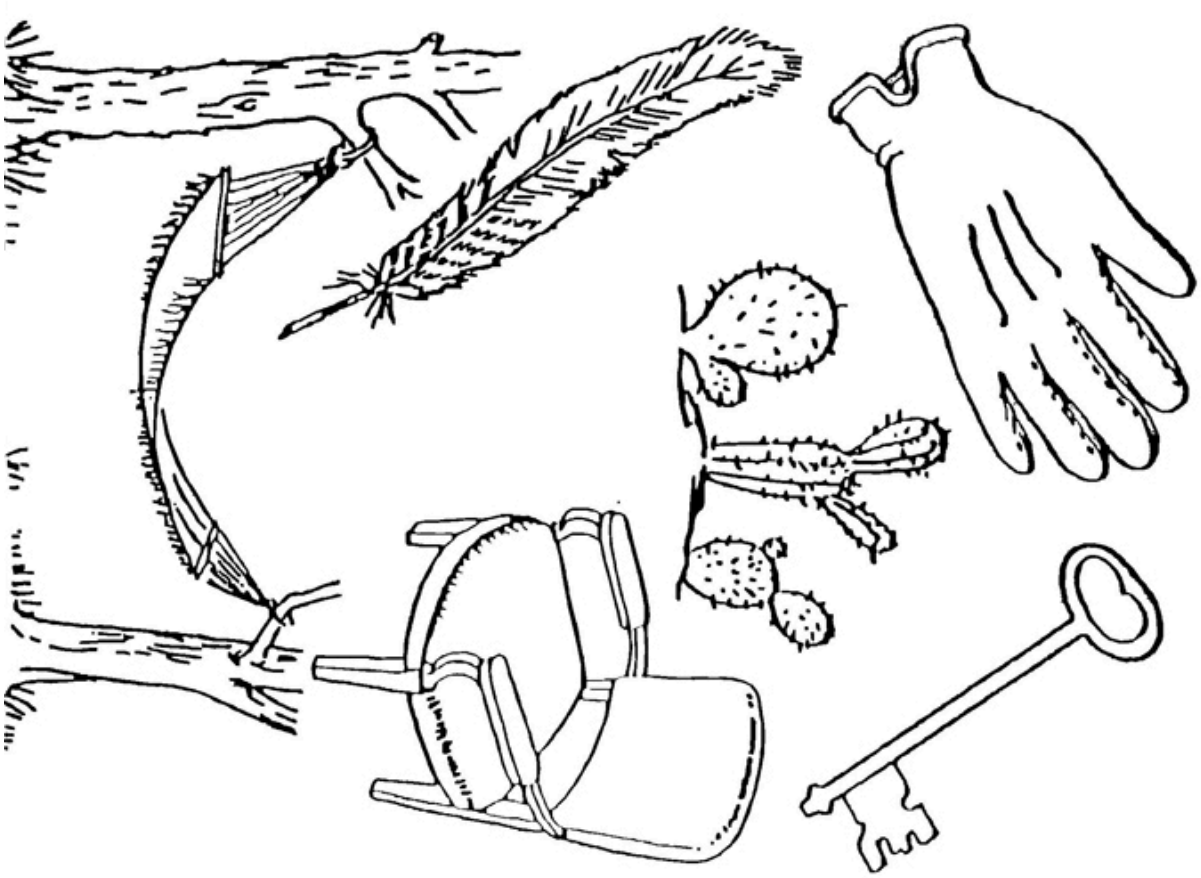

MAMA

TIP-TOP

FIFTY-FIFTY

THANKS

HUCKLEBERRY

BASEBALL PLAYER

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