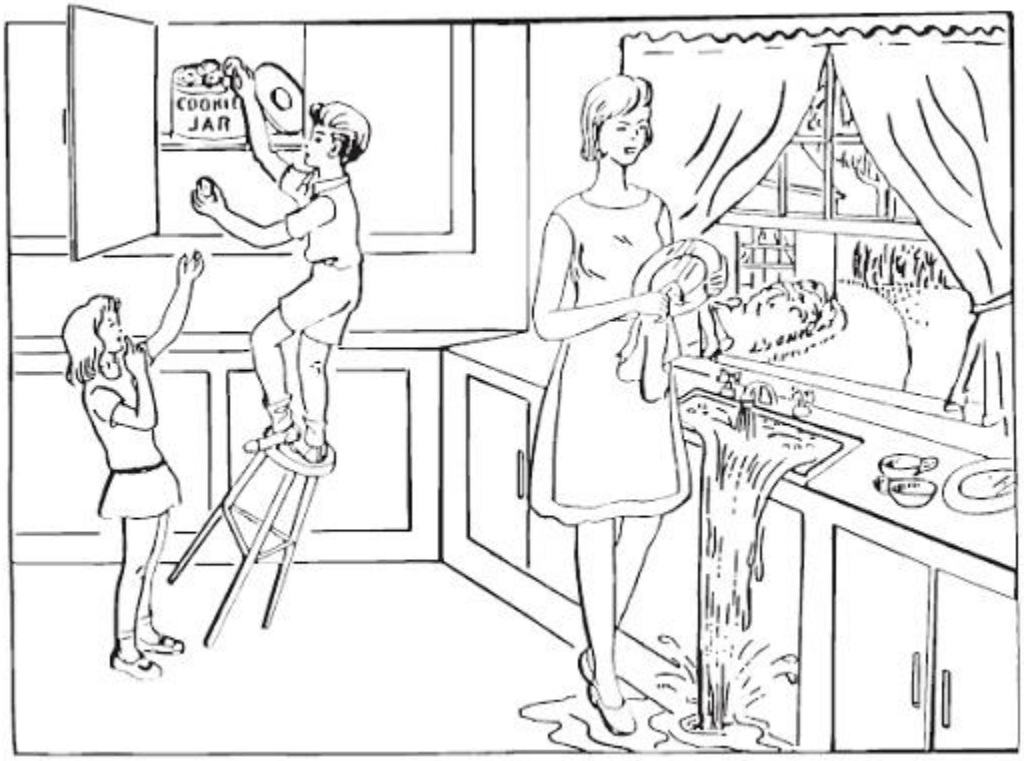
NIH Stroke Scale

		Score
1a. Level of Consciousness:	0 = Alert (eyes open spontaneously) 1 = Arousable (requires minor stimulation to obey, answer, or respond) 2 = Obtunded (requires repeated stimulation to attend) 3 = Coma (responds only with reflex motor or autonomic effects or totally unresponsive)	_____
1b. LOC Questions: *Ask the month and pts age. There is no partial credit for being close. Only the initial answer should be graded and the examiner should not "help" the patient with verbal or non-verbal cues.*	0 = Answers both questions correctly. 1 = Answers one question correctly. Intubation, orotracheal trauma, severe dysarthria or language barrier also scores 1. 2 = Answers neither question correctly. Aphasic and stuporous patients who do not comprehend the questions. Coma = 2	_____
1c. LOC Commands: *Ask or pantomime 2 commands, i.e. close the eyes and make a fist.*	0 = Performs both tasks correctly. 1 = Performs one task correctly. 2 = Performs neither task correctly. Coma = 2.	_____
2. Best Gaze: *Horizontal voluntary (tracking) or reflexive (Doll's maneuver) eye movements are tested.*	0 = Normal; Congenital strabismus, vertical gaze palsy, nystagmus, skew deviation. 1 = Gaze palsy that can be overcome by voluntary or reflexive (Doll's maneuver) eye movement. Isolated oculomotor nerve palsy also scores 1. 2 = Forced deviation that cannot be overcome by voluntary or reflexive eye movements.	_____
3. Visual fields: *Tested by finger counting/hand waving or blink to threat, as appropriate. If there is unilateral blindness or enucleation, test visual fields in the remaining eye.*	0 = No visual loss or monocular vision loss. 1 = Partial hemianopia, quadrantanopia or visual neglect. 2 = Complete hemianopia. 3 = Bilateral blindness (including cortical blindness)	_____
4. Facial Palsy: *Score symmetry of grimace in response to noxious stimuli in the poorly responsive or non-comprehending patient.*	0 = Normal symmetrical movements. 1 = Minor paralysis (flattened nasolabial fold, asymmetry on smiling or grimacing) 2 = Obvious lower facial paralysis (noticeable at rest without facial movement) 3 = Paralysis of the upper and lower face. Coma = 3.	_____
5. Motor Arm: *The limb is placed extend the arms (palms down) 90 degrees (if sitting) or 45 degrees (if supine). The aphasic patient is encouraged using pantomime. Do not apply noxious stimuli for motor response.*	0 = No drift; arm held at 90 (or 45 if lying down) degrees x 10 sec. 1 = Drifts, but does not touch bed x 10 sec. 2 = Drifts down to bed in less than or equal to 10 sec, but has some effort against gravity. 3 = No effort against gravity; arm falls to bed immediately. 4 = No movement or coma. UN = Amputation or joint fusion, explain: _____	LEFT _____ RIGHT _____
6. Motor Leg: *The leg is placed at 30 degrees (always tested supine). The aphasic patient is encouraged using pantomime. Do not apply noxious stimuli for motor response.*	0 = No drift; leg held at 30 degrees x 5 sec. 1 = Drifts, but does not touch bed x 5 sec. 2 = Drifts down to bed in less than or equal to 5 sec, but has some effort against gravity. 3 = No effort against gravity; leg falls to bed immediately. 4 = No movement or coma. UN = Amputation or joint fusion, explain: _____	LEFT _____ RIGHT _____
7. Limb Ataxia: *Finger-nose-finger and heel-shin tests are tested bilaterally. Ataxia is scored only if present out of proportion to weakness.*	0 = Absent. Ataxia is absent in the patient who cannot understand or is paralyzed. 1 = Present in one limb. 2 = Present in two limbs. UN = Amputation or joint fusion, explain: _____ Coma = 0.	_____
8. Sensory: *Sensation to pinprick or grimace to noxious stimuli in the obtunded or aphasic patient. Do not score sensory loss due to cause other than stroke, i.e. neuropathy.*	0 = Normal sensation. 1 = Decreased sensation; pinprick feels less sharp on the affected side. Neglect = 1. 2 = Absent sensation or bilateral sensory loss. Coma = 2.	_____
9. Best Language: *Use of NIHSS cards is not required, but formally assessing fluency, naming, repetition, and comprehension is recommended.*	0 = No aphasia; normal. 1 = Mild-to-moderate aphasia; some obvious loss of fluency or facility of comprehension, without significant limitation on ideas expressed or form of expression. 2 = Severe aphasia; all communication is through fragmentary expression. Range of information that can be exchanged is limited. 3 = Mute, global aphasia; no usable speech or auditory comprehension. Coma = 3.	_____
10. Dysarthria: *If the patient has severe aphasia, the clarity of articulation of spontaneous speech can be rated.*	0 = Normal. 1 = Mild-to-moderate dysarthria; patient slurs at least some words and, at worst, can be understood with some difficulty. 2 = Severe dysarthria; patient's speech is so slurred as to be unintelligible in the absence of or out of proportion to any aphasia or is mute/anarthric. Coma = 2. UN = Intubated or other physical barrier, explain: _____	_____
11. Extinction and Inattention (formerly Neglect): *Score only if present. If the patient has aphasia but does appear to attend to both sides, the score is normal.*	0 = No abnormality detected. 1 = Visual, tactile, auditory, spatial, or personal inattention or extinction to bilateral simultaneous stimulation in one of the sensory modalities. 2 = Profound hemi-inattention or extinction to more than one modality; does not recognize own hand or orients to only one side of space. Coma = 2.	____
TOTAL		____

Examiner:_____ Signature:_____ Date/Time: _____

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.

MAMA
TIP-TOP
FIFTY-FIFTY
THANKS
HUCKLEBERRY
BASEBALL PLAYER


COOKIE
JAR