

Stroke Assessment Across the Continuum of Care

National Institutes of Health Stroke Scale (NIHSS)

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- Interval: 1 () Baseline
 2 () 2 hours post treatment
 3 () 4 hours post onset of symptoms +/- 20 minutes
 4 () 7-10 days
 5 () 3 months
 6 () Other _____

- Time: 1 () am
 2 () pm

Administer stroke scale items in the order listed. Record performance in each category after each subscale exam. Do not go back and change scores. Follow directions provided for each exam technique. Scores should reflect what the patient does, not what the clinician thinks the patient can do. The clinician should record answers while administering the exam and work quickly. Except where indicated, the patient should not be coached (i.e., repeated requests to patient to make a special effort).

Instructions	Scale Definition	Score
<p>1a. Level of Consciousness (LOC): The investigator must choose a response, even if a full evaluation is prevented by such obstacles as an endotracheal tube, language barrier, orotracheal trauma/bandages. A 3 is scored only if the patient makes no movement (other than reflexive posturing) in response to noxious stimulation.</p>	<p>0 = Alert; keenly responsive. 1 = Not alert, but arousable by minor stimulation to obey, answer, or respond. 2 = Not alert, requires repeated stimulation to attend, or is obtunded and requires strong or painful stimulation to make movements (not stereotyped). 3 = Responds only with reflex motor or autonomic effects or totally unresponsive, flaccid, areflexic.</p>	<input type="text"/>
<p>1b. LOC Questions: The patient is asked the month and his/her age. The answer must be correct – there is no partial credit for being close. Aphasic and stuporous patients who do not comprehend the questions will score 2. Patients unable to speak because of endotracheal intubation, orotracheal trauma, severe dysarthria from any cause, language barrier or any other problem not secondary to aphasia are given a 1. It is important that only the initial answer be graded and that the examiner not “help” the patient with verbal or non-verbal cues.</p>	<p>0 = Answers both questions correctly. 1 = Answers one question correctly. 2 = Answers neither question correctly.</p>	<input type="text"/>

Instructions	Scale Definition	Score
<p>1c. LOC Commands: The patient is asked to open and close the eyes and then to grip and release the non-paretic hand. Substitute another one step command if the hands cannot be used. Credit is given if an unequivocal attempt is made but not completed due to weakness. If the patient does not respond to command, the task should be demonstrated to them (pantomime) and score the result (i.e., follows none, one or two commands). Patients with trauma, amputation, or other physical impediments should be given suitable one-step commands. Only the first attempt is scored.</p>	<p>0 = Performs both tasks correctly 1 = Performs one task correctly 2 = Performs neither task correctly</p>	<input data-bbox="1255 258 1406 310" type="text"/>
<p>2. Best Gaze: Only horizontal eye movements will be tested. Voluntary or reflexive (oculocephalic) eye movements will be scored but caloric testing is not done. If the patient has a conjugate deviation of the eyes that can be overcome by voluntary or reflexive activity, the score will be 1. If a patient has an isolated peripheral nerve palsy (Cranial Nerve III, IV or VI) score a 1. Gaze is testable in all aphasic patients. Patients with ocular trauma, bandages, pre-existing blindness or other disorder of visual acuity or fields should be tested with reflexive movements and a choice made by the investigator. Establishing eye contact and then moving about the patient from side to side will occasionally clarify the presence of a partial gaze palsy.</p>	<p>0 = Normal 1 = Partial gaze palsy. This score is given when gaze is abnormal in one or both eyes, but where forced deviation or total gaze paresis are not present 2 = Forced deviation, or total gaze paresis not overcome by the oculocephalic maneuver</p>	<input data-bbox="1255 667 1406 720" type="text"/>
<p>3. Visual: Visual fields (upper and lower quadrants) are tested by confrontation, using finger counting or visual threat as appropriate. Patient must be encouraged, but if they look at the side of the moving fingers appropriately, this can be scored as normal. If there is unilateral blindness or enucleation, visual fields in the remaining eye are scored. Score 1 only if a clear-cut asymmetry, including quadrantanopia is found. If patient is blind from any cause score 3. Double simultaneous stimulation is performed at this point. If there is extinction patient receives a 1 and the results are used to answer question 11.</p>	<p>0 = No visual loss 1 = Partial hemianopia 2 = Complete hemianopia 3 = Bilateral hemianopia (blind including cortical blindness)</p>	<input data-bbox="1255 1192 1406 1245" type="text"/>
<p>4. Facial Palsy: Ask, or use pantomime to encourage the patient to show teeth or raise eyebrows and close eyes. Score symmetry of grimace in response to noxious stimuli in the poorly responsive or non-comprehending patient. If facial trauma/bandages, orotracheal tube, tape or other physical barrier obscures the face, these should be removed to the extent possible.</p>	<p>0 = Normal symmetrical movement 1 = Minor paralysis (flattened nasolabial fold, asymmetry on smiling) 2 = Partial paralysis (total or near total paralysis of lower face) 3 = Complete paralysis of one or both sides (absence of facial movement in the upper and lower face)</p>	<input data-bbox="1255 1629 1406 1682" type="text"/>

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<p>5 & 6. Motor Arm and Leg: The limb is placed in the appropriate position: extend the arms (palms down) 90 degrees (if sitting) or 45 degrees (if supine) and the leg 30 degrees (always tested supine). Drift is scored if the arm falls before 10 seconds or the leg before 5 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime but not noxious stimulation. Each limb is tested in turn, beginning with the non-paretic arm. Only in the case of amputation or joint fusion at the shoulder or hip may the score be “9” and the examiner must clearly write the explanation for scoring as a “9”.</p>	<p>0 = No drift, limb holds 90 (or 45) degrees for full 10 seconds 1 = Drift, limb holds 90 (or 45) degrees, but drifts down before full 10 seconds; does not hit bed or other support 2 = Some effort against gravity, limb cannot get to or maintain (if cued) 90 (or 45) degrees, drifts down to bed, but has some effort against gravity 3 = No effort against gravity, limb falls 4 = No movement 9 = Amputation, joint fusion explain: _____</p> <p>5a. Left Arm <input data-bbox="1255 640 1406 693" type="text"/></p> <p>5b. Right Arm <input data-bbox="1255 699 1406 751" type="text"/></p> <p>0 = No drift, leg holds 30 degrees position for full 5 seconds 1 = Drift, leg falls by the end of the 5 second period but does not hit bed 2 = Some effort against gravity; leg falls to bed by 5 seconds, but has some effort against gravity 3 = No effort against gravity, leg falls to bed immediately 4 = No movement 9 = Amputation, joint fusion explain: _____</p> <p>6a. Left Leg <input data-bbox="1255 1098 1406 1150" type="text"/></p> <p>6b. Right Leg <input data-bbox="1255 1157 1406 1209" type="text"/></p>	
<p>7. Limb Ataxia: This item is aimed at finding evidence of a unilateral cerebellar lesion. Test with eyes open. In case of visual defect, insure testing is done in intact visual field. The finger-nose-finger and heel-shin tests are performed on both sides, and ataxia is scored only if present out of proportion to weakness. Ataxia is absent in the patient who cannot understand or is paralyzed. Only in the case of amputation or joint fusion may the item be scored “9”, and the examiner must clearly write the explanation for not scoring. In case of blindness test by touching nose from extended arm position.</p>	<p>0 = Absent 1 = Present in one limb 2 = Present in two limbs. If present, is ataxia in: Right arm 1 = Yes 2 = No 9 = Amputation or joint fusion, explain: _____</p> <p>Left arm 1 = Yes 2 = No 9 = Amputation or joint fusion, explain : _____</p> <p>Right leg 1 = Yes 2 = No 9 = Amputation or joint fusion, explain: _____</p> <p>Left leg 1 = Yes 2 = No 9 = Amputation or joint fusion, explain: _____</p>	<input data-bbox="1255 1335 1406 1388" type="text"/> <input data-bbox="1255 1419 1406 1472" type="text"/> <input data-bbox="1255 1503 1406 1556" type="text"/> <input data-bbox="1255 1587 1406 1640" type="text"/> <input data-bbox="1255 1671 1406 1724" type="text"/>

Instructions	Scale Definition	Score
<p>8. Sensory: Sensation or grimace to pin prick when tested, or withdrawal from noxious stimulus in the obtunded or aphasic patient. Only sensory loss attributed to stroke is scored as abnormal and the examiner should test as many body areas [arms (not hands), legs, trunk, face] as needed to accurately check for hemisensory loss. A score of 2, “severe or total,” should only be given when a severe or total loss of sensation can be clearly demonstrated. Stuporous and aphasic patients will therefore probably score 1 or 0. The patient with brain stem stroke who has bilateral loss of sensation is scored 2. If the patient does not respond and is quadriplegic score 2. Patients in coma (item 1a=3) are arbitrarily given a 2 on this item.</p>	<p>0 = Normal; no sensory loss. 1 = Mild to moderate sensory loss; patient feels pinprick is less sharp or is dull on the affected side; or there is a loss of superficial pain with pinprick but patient is aware he/she is being touched. 2 = Severe to total sensory loss; patient is not aware of being touched in the face, arm and leg.</p>	<input data-bbox="1255 283 1406 333" type="text"/>
<p>9. Best Language: A great deal of information about comprehension will be obtained during the preceding sections of the examination. The patient is asked to describe what is happening in the attached picture, to name the items on the attached naming sheet, and to read from the attached list of sentences (see page 95). Comprehension is judged from responses here as well as to all of the commands in the preceding general neurological exam. If visual loss interferes with the tests, ask the patient to identify objects placed in the hand, repeat, and produce speech. The intubated patient should be asked to write. The patient in coma (question 1a=3) will arbitrarily score 3 on this item. The examiner must choose a score in the patient with stupor or limited cooperation but a score of 3 should be used only if the patient is mute and follows no one step commands.</p>	<p>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. Reduction of speech and/or comprehension, however, makes conversation about provided material difficult or impossible. For example in conversation about provided materials examiner can identify picture or naming card from patient’s response. 2 = Severe aphasia; all communication is through fragmentary expression; great need for inference, questioning, and guessing by the listener. Range of information that can be exchanged is limited; listener carries burden of communication. Examiner cannot identify materials provided from patient response. 3 = Mute, global aphasia; no usable speech or auditory comprehension.</p>	<input data-bbox="1255 779 1406 829" type="text"/>
<p>10. Dysarthria: If patient is thought to be normal an adequate sample of speech must be obtained by asking patient to read or repeat words from the attached list (see page 95). If the patient has severe aphasia, the clarity of articulation of spontaneous speech can be rated. Only if the patient is intubated or has other physical barrier to producing speech, may the item be scored “9”, and the examiner must clearly write an explanation for not scoring. Do not tell the patient why he/she is being tested.</p>	<p>0 = Normal 1 = Mild to moderate; patient slurs at least some words and, at worst, can be understood with some difficulty. 2 = Severe; patient’s speech is so slurred as to be unintelligible in the absence of or out of proportion to any dysphasia, or is mute/anarthric. 9 = Intubated or other physical barrier, explain: _____</p>	<input data-bbox="1255 1417 1406 1467" type="text"/>

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<p>11. Extinction and Inattention (formerly Neglect): Sufficient information to identify neglect may be obtained during the prior testing. If the patient has a severe visual loss preventing visual double simultaneous stimulation, and the cutaneous stimuli are normal, the score is normal. If the patient has aphasia but does appear to attend to both sides, the score is normal. The presence of visual spatial neglect or anosognosia may also be taken as evidence of abnormality. Since the abnormality is scored only if present, the item is never untestable.</p>	<p>0 = No abnormality. 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 hemi-inattention to more than one modality. Does not recognize own hand or orients to only one side of space.</p>	<input data-bbox="1255 275 1406 323" type="text"/>

TOTAL:

Person Administering Scale

(Code)



NIHSS #9: Best Language

Client is asked to describe what is happening in the picture:



Client is asked to name the items in the picture:



Client is asked to read from the list of 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.

NIHSS #10: Dysarthria

Client is asked to read and pronounce a standard list of words:

- MAMA
- TIP-TOP
- FIFTY-FIFTY
- THANKS
- HUCKLEBERRY
- BASEBALL PLAYER
- CATERPILLAR