Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown	

NIH Stroke Scale

Handedness ☐ right ☐ unknown ☐ left ☐ both	**Date** *(dd-Mon-yyyy)*								
Category	**NIHSS Score/Description** *(UN=Untestable)*	**Time** *(hh:mm)*							
1a. Level of Consciousness (LOC) *(Alert, drowsy, etc.)*	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 and areflexic								
1b. LOC Questions *(Month, age)*	0 = Answers both correctly 1 = Answers one correctly 2 = Answers neither correctly								
1c. LOC Commands *(Open/close eyes, make fist, let go, may pantomime)*	0 = Performs both tasks correctly 1 = Performs one task correctly 2 = Performs neither task correctly								
2. Best Gaze *(Eyes open- patient follows examiner's finger or face)*	0 = Normal 1 = Partial gaze palsy - gaze is abnormal in one or both eyes, but forced deviation or total gaze paresis is not present 2 = Forced deviation, or total gaze paresis not overcome by the occulocephalic maneuver								
3. Visual *(Introduce visual stimulus/threat to patient's visual field quadrants).* Test each eye separately.	0 = No visual loss 1 = Partial hemianopia 2 = Complete hemianopia 3 = Bilateral hemianopia *(blind including cortical blindness)*								
4. Facial Palsy *(Show teeth, raise eyebrows and squeeze eyes shut)*	0 = Normal symmetrical movements 1 = Minor paralysis *(flattened nasolabial fold, asymmetry of 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)*								
NIHSS Score - Page 1 - carry to Page 4									

Adapted from the National Institute of Neurological Disorders and Stroke (NINDS), National Institutes of Health (NIH) material.
https://www.ninds.nih.gov/stroke-scales-and-related-information

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NIH Stroke Scale

		Date *(dd-Mon-yyyy)*							
Category	**NIHSS Score/Description** *(UN=Untestable)*	**Time** *(hh:mm)*							
5. Motor Arm *(Elevate with palm down. 45 degrees if lying, 90 degrees if sitting. 10 second count)* Score drift/ movement.	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 supports 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 UN = Amputation or joint fusion, explain: _____ **5a. Left Arm**								
	5b. Right Arm								
6. Motor Leg *(Elevate 30 degrees while supine. 5 second count)* Score drift/ movement.	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 UN = Amputation or joint fusion, explain: _____ **6a. Left Leg**								
	6b. Right Leg								
	NIHSS Score - Page 2 - carry to Page 4								

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NIH Stroke Scale

		Date *(dd-Mon-yyyy)*							
Category	**NIHSS Score/Description** *(UN=Untestable)*	**Time** *(hh:mm)*							
7. Limb Ataxia *(Finger-nose, heel down shin)*	0 = Absent 1 = Present in one limb Right Arm: ☐ Yes ☐ No Left Arm: ☐ Yes ☐ No 2 = Present in two limbs UN = Amputation or joint fusion, explain: _____								
8. Sensory *(Pin prick to face, arm, trunk and leg-compare side to side)*	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 of being touched 2 = Severe to total sensory loss; patient is not aware of being touched in the face, arm & leg								
9. Best Language *(Name items, describe a picture and read sentences)*	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 materials difficult or impossible. For example, in conversation about provided materials, examiner can identify picture or naming card content 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								
NIHSS Score - Page 3 - carry to Page 4									

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NIH Stroke Scale

		Date *(dd-Mon-yyyy)*							
Category	**NIHSS Score/Description** *(UN=Untestable)*	**Time** *(hh:mm)*							
10. Dysarthria *(Evaluate speech clarity by patient repeating listed words)*	0 = Normal 1 = Mild to mod 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 dysphasia, or is mute/anarthric UN = Intubated or other physical barrier explain: _____								
11. Extinction and Inattention *(Neglect)* *(Use information from prior testing to identify neglect or double simultaneous stimuli testing)*	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 extinction to more than one modality; does not recognize own hand or orients to only one side of space								
Total NIHSS Score from this page:									
Total from Page 1									
Total from Page 2									
Total from Page 3									
Total NIHSS Score *(added scores from pages 1, 2, 3 and 4)*									
Initials									

Name *(print)*	**Signature**	**Initials**

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NIH Stroke Scale

Reference Tool

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

1 a. Level of Consciousness

The investigator must choose a response 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.

1 b. 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

1 c. 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 him or her (pantomime), and the result scored (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.

2. Best Gaze

Establish eye contact and ask the patient to: "Follow my finger."

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 paresis (CN 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.

3. Visual

Visual fields (upper and lower quadrants) are tested by confrontation, using finger counting or visual threat, as appropriate. Patients may 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 respond to item 11.

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NIH Stroke Scale

Reference Tool (continued)

Instructions

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 barriers obscure the face, these should be removed to the extent possible.

5 & 6. Motor Arm and Leg

Motor Arm

The limb is placed in the appropriate position: extend the arms (palms down) 90 degrees (if sitting) or 45 degrees (if supine). Drift is scored if the arm falls before 10 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, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.

Motor Leg

The limb is placed in the appropriate position: hold the leg at 30 degrees (always tested supine). Drift is scored if the leg falls 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 leg. Only in the case of amputation or joint fusion at the hip, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.

7. Limb Ataxia

Ask patient (eyes open) to: “Touch your finger to your nose. Touch your heel to your shin.”

This item is aimed at finding evidence of a unilateral cerebellar lesion. Test with eyes open. In case of visual defect, ensure 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, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice. In case of blindness, test by having the patient touch nose from extended arm position.

8. Sensory

Test as many body parts as possible (arms [not hands], legs, trunk, face) for sensation using pinprick or noxious stimulus (in the obtunded or aphasic patient).

Sensation or grimace to pinprick 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 sensory loss,” 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 brainstem stroke who has bilateral loss of sensation is scored 2. If the patient does not respond and is quadriplegic, score 2. Patients in a coma (item 1a=3) are automatically given a 2 on this item.

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NIH Stroke Scale

Reference Tool (continued)

Instructions

9. Best Language

Using pictures and the sentence list attached to NIHSS scoring form, ask the patient to: “Describe what you see in this picture. Name the items in this picture. Read these sentences.”

A great deal of information about comprehension will be obtained during the preceding sections of the examination. For this scale item, 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. 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 a coma (item 1a=3) will automatically score 3 on this item. The examiner must choose a score for 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.

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. 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 barriers to producing speech, the examiner should record the score as untestable (UN), and clearly write an explanation for this choice. Do not tell the patient why he or she is being tested.

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 anosagnosia may also be taken as evidence of abnormality. Since the abnormality is scored only if present, the item is never untestable.

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NIH Stroke Scale

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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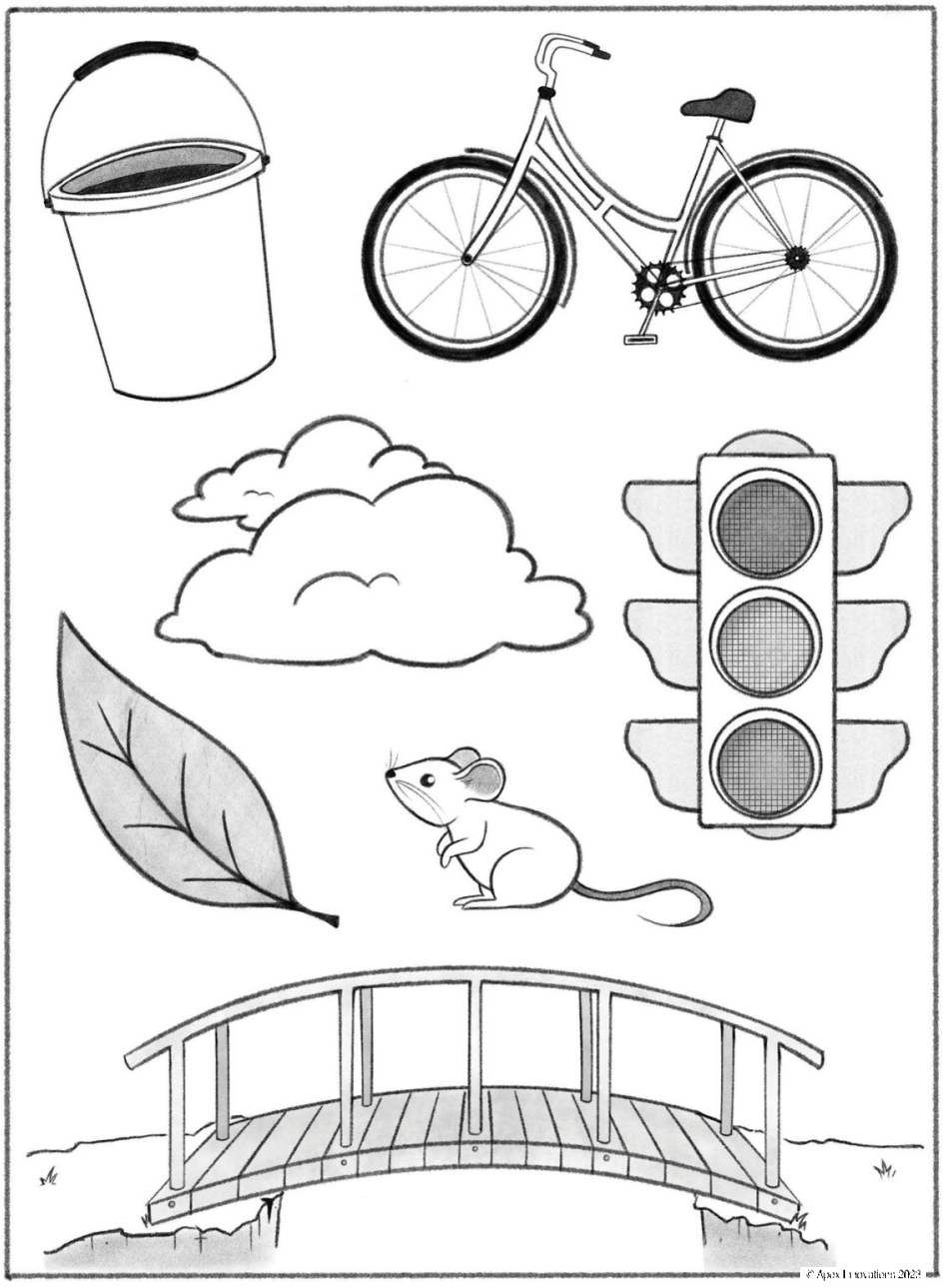
NIH Stroke Scale



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NIH Stroke Scale

MAMA

TIP-TOP

FIFTY-FIFTY

THANKS

HUCKLEBERRY

BASEBALL PLAYER

CATERPILLAR