Capital Area School of Practical Nursing
Head to Toe Adult Physical Assessment

Student's Name: _____ Date: _____

Task	Comments
Patient initials and Age	
Diagnosis	
Identify the patient using two identifiers, introduce yourself, explain the procedure and wash your hands	
Assess general body structure, height, weight and BMI	
Obtain Vital Signs including pain scale	
Measure pulse oximeter	
Assess LOC and orientation x3 (person, place and time)	
Assess facial expression and reaction to caregiver	
Assess hygiene, grooming, dress, odors, etc.	
Assess speech and describe any abnormalities	
Assess mood/affect	
Assess face for symmetry	
Assess eyelids for drooping/sagging	
Inspect/palpate head for size, shape, hair distribution and color, tenderness or abnormalities	
Assess symmetry, shape, and size of each pupil	
Inspect pupil response by shining light into each pupil	
Assess eye movement by moving penlight in different directions	
Assess vision (use of glasses)	
Assess ears for shape, placement, symmetry and discharge	

Assess hearing (use of hearing aids)	
Assess placement of nose and patency of nares	
Assess nasal mucosa by shining pen light	
Assess any drainage and assess septum for deviation	
Assess mouth, lips, and oral mucosa	
Assess condition of gums and teeth	
Assess tongue and check for midline protrusion	
Inspect and palpate neck for trachea placement, tenderness or any abnormalities	
Palpate carotid arteries (one at a time)	
Check range of neck motion	
Inspect skin for any lesions, discolorations, or abnormalities throughout assessment. (esp. bony prominences)	
Palpate skin for color, temperature, moisture	
Assess for dehydration by pinching skin over clavicle	
Palpate radial pulses	
Palpate brachial pulses (if applicable)	
Assess capillary refill	
Check for clubbing	
Assess ROM and muscle strength in upper extremities	
Inspect respirations	
Assess use of accessory muscles and posture	
Describe any cough or sputum	
Inspect anterior/posterior thorax for symmetry and note any abnormalities	
Inspect spine	
Use stethoscope to auscultate over all lung fields (6 posterior, 2 anterior, and axilla regions)	
Palpate anterior/posterior chest for any tenderness or abnormalities	
Auscultate apical pulse (60 sec)	
Assess heart rhythm	

Inspect abdomen for symmetry and describe any abnormalities	
Auscultate the abdomen in all 4 quadrants	
Palpate abdomen in all 4 quadrants to note any tenderness	
Assess patient appetite, diet, last bowel movement and any c/o nausea, vomiting, diarrhea, constipation	
Assess genitourinary/bladder (frequency, urgency, pain, distention)	
Assess urine color, odor, continence	
Palpate femoral artery (if applicable)	
Assess ROM and muscle strength in lower extremities	
Test motor function and balance together with gait assessment	
Assess popliteal, posterior tibial pulses (if applicable)	
Assess dorsalis pedis (pedal) pulses	
Identify presence of edema	
Miscellaneous assessment data, tubes, drains, casts, splints, dressings, IV's, etc.	
Document assessment per facility policy	