Head-to-Toe Assessment

Nursing

A repeatable order for a full assessment, so nothing is left out.

General survey first, then a fixed anatomical route, then the record.

1. **General survey**
   Appearance, posture, distress, hygiene, speech, observations.
2. **Head and neck**
   Level of consciousness, pupils, mouth, skin, neck vessels.
3. **Chest**
   Respiratory effort, breath sounds, heart sounds, chest wall.
4. **Abdomen**
   Contour, bowel sounds, tenderness, output, last bowel motion.
5. **Limbs and skin**
   Perfusion, oedema, pressure areas, movement, wounds, lines.
6. **Record and compare**
   Document findings and set them against the last assessment.

Educational reference. A comprehensive assessment establishes the baseline; focused reassessment tracks change against it.