

NIH Stroke Scale

Name:

Hospital:

Date of Birth:

Physician/Nurse's Name: Signature:

Date:

Instruction	Scale Definition	Score			
		Baseline	hours after treatment	24 hours after treatment	Other:
Date and Time:					
1.a. Level of Consciousness	0 = Alert, keenly responsive 1 = Not alert but arousable by minor stimulation to obey, answer, respond 2 = Not alert; requires repeat stimulation; is obtunded, requires strong stimuli to respond 3 = Reflex motor or autonomic effects response, totally unresponsive, flaccid				
1b. Level of Consciousness Questions Ask the patient the month and their age.	0 = Answers both questions correctly. 1 = Answers one question correctly. 2 = Answers neither question correctly.				
1c. Level of Consciousness Commands Ask the patient to open and close their eyes. Then, grip and release the non-paretic hand.	0 = Performs both tasks correctly. 1 = Performs one task correctly. 2 = Performs neither task correctly.				
2. Best Gaze Ask the patient to follow a finger/object across horizontal eye movements *For unconscious patients: Use the oculocephalic maneuver.	0 = Normal 1 = Partial Gaze Palsy; the gaze is abnormal in 1 or both eyes. No forced deviation or total gaze paresis. 2 = Complete Gaze Palsy; total gaze paresis not overcome by oculocephalic man				
3. Visual Ask the patient to look at your nose or eyes. Make an imaginary four quadrants in front of you and move your finger to each of the quadrants. Ask the patient if they can detect movement in any or all of the quadrants.	0 = No visual loss 1 = Partial hemianopia 2 = Complete hemianopia 3 = Bilateral hemianopia (including cortical blindness)				

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4. Facial Palsy Ask the patient to smile OR show teeth, raise eyebrows, and close eyes.	0 = Normal symmetrical movements 1 = Minor paralysis (there's a flattened nasolabial fold, asymmetry on smiling) 2 = Partial paralysis (there's total or near-total paralysis of the lower face) 3 = Complete paralysis of one or both sides (there's an absence of facial movement in the upper and lower face)				
5. Motor Arm Ask the patient to extend and hold out one limb at a time for 10 seconds at: • Palms down at 90 degrees (if sitting) • Palms down at 45 degrees (if supine)	0 = No drift; limb holds 90°(or 45°) for full 10 seconds 1 = Drift; limb holds 90°(or 45°) but drifts down before full 10 seconds. Does not hit the bed or other support 2 = Some effort against gravity; limb cannot get to or maintain (if cued 90°or 45°). Drifts down to bed and has some effort against gravity. 3 = No effort against gravity; limb falls 4 = No movement *UN = Amputation, joint fusion. Explanation:	Left:	Left:	Left:	Left:
		Right:	Right:	Right:	Right:
6. Motor Leg Have your patient be in a supine position. Ask them to hold their leg at 30 degrees for 5 seconds.	0 = No drift; leg holds 30-degree position for full 5 seconds 1 = Drift; leg falls by the end of the 5-second period. Does not hit the 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. Explanation:	Left:	Left:	Left:	Left:
		Right:	Right:	Right:	Right:
7. Limb Ataxia Ask the patient to do the test one limb, one side at a time: • Finger-Nose-Finger • Heel to shin	0 = Absent 1 = Present in one limb 2 = Present in two limbs *UN = Amputation, joint fusion Explanation:				
8. Sensory Make pinpricks on the patient's face, arms, and legs on one side and then the other.	0 = Normal; no sensory loss 1 = Mild-to-moderate sensory loss; patient feels the pinprick is less sharp, is dull on the affected side, and there is a loss of superficial pain with a pinprick. The patient is still aware of being touched 2 = Severe to total sensory loss; the patient is not aware of being touched in the face, arm, and leg				
9. Best Language *Refer to the attached cards Ask the patient to: • Describe what is happening in the picture • Name the objects • Read the list of sentences	0 = No aphasia, normal 1 = Mild/moderate aphasia; obvious loss of fluency/facility of comprehension, no significant limitation on ideas expressed, reduced speech/comprehension. Can still make conversation about what's in the picture. 2 = Severe aphasia; fragmented expression, guesses, questions, has limited exchange of information resulting in the listener carrying the conversation. 3 = Mute; global aphasia; no usable speech; or auditory comprehension				

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10. Dysarthria Ask the patient to read/repeat the words on the attached list	0 = Normal 1 = Mild-to-moderate dysarthria; the patient slurs at some words. 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/out of proportion to any dysphasia, or is mute/anarthric UN = Intubated or other physical barrier. Explanation:				
11. Extinction & Inattention Visual: Repeat the instructions in #3 (You may place hands on 2 quadrants simultaneously) or show your patient their plegic arm and ask whose arm it is. Tactile: Ask the patient if you may touch them. If they say yes, proceed with touching one limb, the other, and then both. Ask them which limb was touched every time.	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 semi-inattention or extinction to more than one modality; does not recognize own hand or orients to only one side.				
TOTAL SCORE:					