Site_____

Patient Code_____

Examiner _____
(print name)

(Signature) _____

Specialty _____

Date of Examination _____

NIH STROKE SCALE

(Note: This evaluation is to be done only at admission, at the end of weeks 1, 2, and 3, and at the end of 3 months, by the same investigator. The primary study outcome will depend upon these evaluations.)

Administrator 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
1a. Level of Consciousness: The investigator must choose a response, even if a full evaluation is prevented by such obstacles as an endotracheal tube, language barrier, oro-tracheal trauma/bandages. A **3** is scored only if the patient makes no movement (other than reflexive posturing in response to noxious stimulation.	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.	_____
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, oro-tracheal 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 nonverbal cues.	0 = Answers both questions correctly 1 = Answers one question correctly 2 = Answers neither question correctly	_____
1c. LOC Commands: The patient is asked to open and close the eyes and then to grip and release the nonparetic 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.	0 – Performs both tasks correctly 1 = Performs one task correctly 2 = Performs neither task correctly	_____
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 paresis (CN III, IV, or V), score a **1**. Gaze is testable in all aphasic patients. Patients with ocular trauma, bandages, preexisting 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 gaze palsy.	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 is not present. 2 = Forced deviation or total gaze paresis not overcome by the oculocephalic maneuver.	_____

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 he or she looks 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 quadrantaponia, is found. If patient is blind from any cause, score **3**. Double stimulation is performed at this point. If there is extinction, patient receives a **1** and the results are used to answer question 11.	0 = No visual loss 1 = Partial hemianopia 2 = Complete hemianopia 3 = Bilateral hemianopia (blind including cortical blindness)	_____
4. Facial Palsy: Ask or use pantomime to encourage the patient to show teeth or smile and close eyes. Score symmetry of grimace in response to noxious stimuli in the poorly responsive or noncomprehending patient. If facial trauma/bandages, orotracheal tube, tape, or other physical barrier obscures the face, these should be removed to the extent possible.	0 = Normal symmetrical movement 1 = Minor paralysis (flattened nasolabial fold, 2 = Partial paralysis (total or near total paralysis of lower face) 3 = Complete paralysis (absence of facial movement in the upper and lower face)	_____
5 and 6. Motor Arm and Leg: The limb is placed in the appropriate position; extend the arms 90^{o} (if sitting) or 45^{o} (if supine) and the leg 30^{o} (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 as a **9**.	0 = No drift; limb holds 90^{o} (or 45^{o}) for full 10 seconds. 1 = Drift; limb holds 90^{o} (or 45^{o}) 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^{o} (or 45^{o}), 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:_____ 5a = Left arm 5b = Right arm	_____ _____
	0 = No drift, leg holds 30^{o} 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:_____ 6a = Left leg 6b = Right leg	_____ _____

7. Limb Ataxia: 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 hemiplegic, 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.	0 = Absent 1 = Present in one limb 2 = Present in both limbs If present, is ataxia in Right arm: 1 = Yes 2 = No 9 = Amputation or joint fusion; explain_____ Left arm: 1 = Yes 2 = No 9 = Amputation or joint fusion; explain_____ Right leg: 1 = Yes 2 = No 9 = Amputation or joint fusion; explain_____ Left leg: 1 = Yes 2 = No 9 = Amputation or joint fusion; explain_____	_____ _____ _____ _____ _____
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 (question 1a=3) are arbitrarily given a **2** on this item.	0 = Normal; no sensory loss 1 = Mild to moderate sensory loss; patient feels pin prick is less sharp or is dull on the affected side, or there is a loss of superficial pain with pin prick but patient is aware he or she is being touched. 2 = Severe to total sensory loss; patient is not aware of being touched.	_____
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. 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 sentence. 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.	0 = No aphasia, normal 1 = Mild to moderate aphasia; some obvious loss of 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.	_____

10. Dysarthria: If a 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 barrier to producing speech, may be 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.	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 _____	_____
11. Extinction and Inattentioin (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 not 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.	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.	_____

Sentences for 9. Best Language

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.

Word List for 10. Dysarthria

Mama

Tip-Top

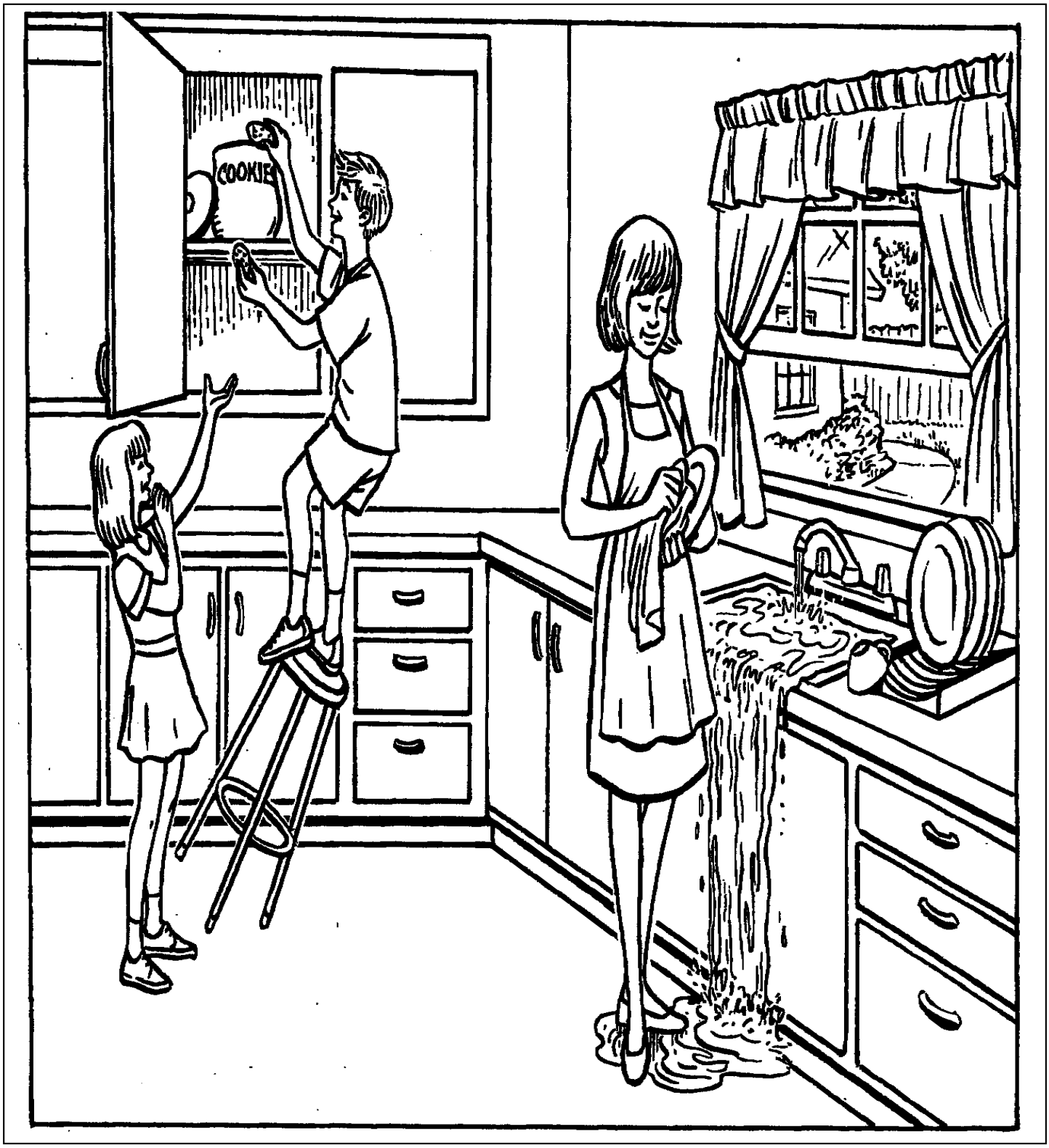
Fifty-Fifty

Thanks

Huckleberry

Baseball Player

Picture for 9. Best Language



Naming Sheet for 9. Best Language