Head-to-Toe Checklist

(For use with Body Condition Diagram)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_

This form must be completed when any injury is noted and/or following any fall.

Direction (X ) appropriate column. If "yes" describe assessment findings and follow up in the COMMENT section below.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | Problem | |  | | Problem | |
| Yes | No | Yes | No |
| Head: | Face |  |  | Back: | Upper |  |  |
| Eyes |  |  | Lower |  |  |
| Ears |  |  | Buttocks |  |  |
| Mouth |  |  | Lower Body: | Waist |  |  |
| Scalp |  |  |  |  |
| **If** yes, **include** neurological check form. | |  |  | Abdomen |  |  |
| Neck: | Front |  |  | Upper Legs |  |  |
| Back |  |  | Knees |  |  |
| Upper Body: | Shoulders |  |  | Ankles |  |  |
|  |  | Feet |  |  |
| Upper Arms |  |  | Toes |  |  |
| Elbows |  |  |  |  |  |
| Lower Arms |  |  |  |  |  |
| Wrists |  |  |  |  |  |
| Hands |  |  |  |  |  |
| Fingers |  |  |  |  |  |
| Chest |  |  |  |  |  |

Signature/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RN Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Admin Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date/Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BODY CONDITION DIAGRAM

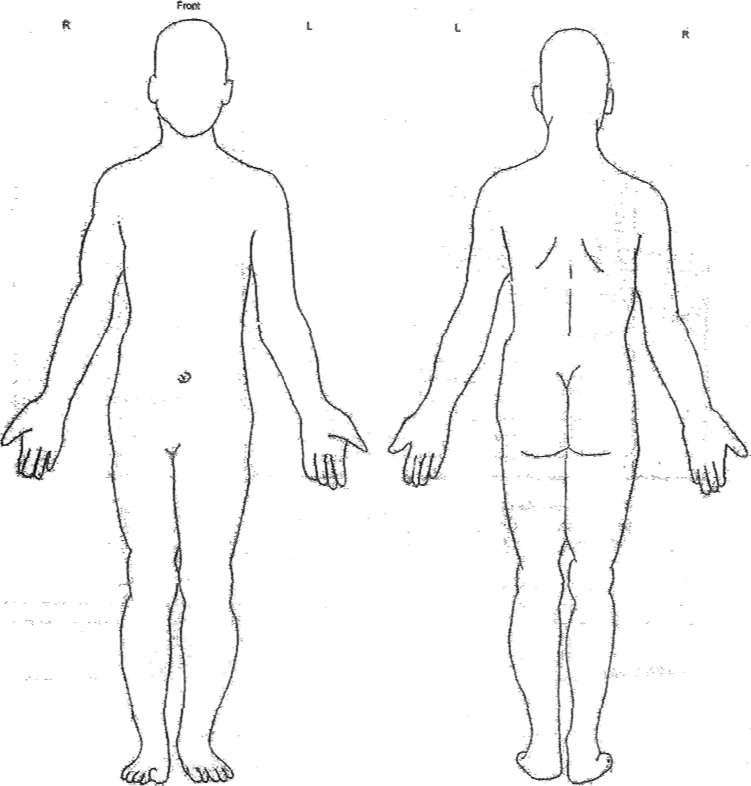
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_

Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identify each area, size, and time of observation. (Remember to also complete Head-to-Toe Checklist form.)



Is there a breakdown of skin integrity, (i.e.: scrape, cut, bruise, redness, warmth, swelling, rash, etc) Describe size of wound and specific location. Is there pain, tenderness, weakness, loss of use or deformity? Is there bleeding or drainage? Describe type and amount.

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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RN Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_