Head and Neck Assessment

Patient information

Name: Lucas Porter **Date of birth:** April 15, 1985

Contact information: (123) 456-7890 **Date of assessment:** March 1, 2025

Medical history
Patient reports occasional neck pain and headaches but denies any history of trauma. No history of thyroid disease or significant infections.

Preparation

- Ensure the patient is comfortable and understands the procedure.
- Gather all necessary supplies (penlight, tongue blade, nonsterile gloves, etc.).
- Remove any accessories or clothing that might obstruct the view of the head and neck.
- Confirm patient identification.

Assessment procedure

I. Inspection
A. Head and face
Procedure: Inspect the skin for color, texture, symmetry, swelling, masses, or deformities. Assess facial expressions and movements.
Documentation:
Skin is intact, with normal color and texture. No visible lesions or swelling. Facial symmetry is present, and movements are normal.
B. Nose
Procedure: Examine the external nose for drainage, obstructions, or any visible deformities.
Documentation:
No nasal discharge, septum midline, and no visible obstructions or deformities.

C. Oral cavity

Procedure: Evaluate the oral cavity, including the tongue, uvula, and throat. Look for lesions, abnormal positions, and tonsil enlargement.

Documentation:

Oral mucosa is pink and moist. No lesions noted. Tonsils are non-enlarged, uvula midline, and tongue movement normal.

D. Neck

Procedure: Visually inspect the neck for asymmetry, masses, deformities, or tracheal deviation.

Documentation:

Trachea is midline, no visible masses or deformities. No asymmetry detected.

II. Palpation

A. Cranium

Procedure: For infants, observe head control and muscle strength. Palpate the scalp and cranium to check for masses, indentations, or signs of skin breakdown.

Documentation:

No palpable abnormalities, no tenderness or signs of skin breakdown.

B. Lymph nodes

Procedure: Systematically palpate the lymph node groups for size, tenderness, or irregularities.

Documentation:

No palpable swollen lymph nodes. No tenderness noted.

C. Cervical spine

Procedure: Palpate the cervical spine and surrounding muscles to detect any pain, spasms, or masses.

Documentation:

Full range of motion without pain. No muscle spasms or tenderness.

III. Additional assessments
A. Cranial nerve evaluation
Procedure: Test facial sensation and motor function by assessing movements and responses.
Documentation:
No deficits noted. Symmetric facial movements with normal sensory response.
B. Swallowing assessment
Procedure: Observe the patient's ability to swallow, noting any difficulties or abnormal patterns.
Documentation:
Swallowing intact, no choking, coughing, or aspiration observed.
C. Speech evaluation
Procedure: Assess the clarity and articulation of the patient's speech during conversation.
Documentation:
Assess clarity and articulation during conversation.
D. Cervical range of motion
Procedure: Evaluate the range of motion of the cervical spine by asking the patient to perform flexion, extension, lateral bending, and rotation.
Documentation:
Full active range of motion. No pain or restrictions noted.
E. Ear inspection
Procedure: Inspect the external ears for any abnormalities, discharge, or deformities.
Documentation:
No signs of infection, discharge or deformities.

Results and summary of findings

I. Inspection and palpation summary
Inspection and Palpation Summary: No visible abnormalities in head, neck, or facial structures. No masses or swelling detected. Lymph nodes non-palpable. Additional Assessments Summary: Cranial nerve function intact, normal speech clarity and swallowing function. Full cervical spine range of motion.

II. Additional assessments summary
None

Additional notes

Patient denies pain, dizziness, or neurological symptoms. No immediate medical concerns identified.

Healthcare professional information

Name: Dr. Danica Fuller, MD **License ID number:** 12345678

Signature: **Dr. Danica Fuller, MD** **Date:** March 1, 2025