Head and Neck Assessment

Patient information

Name:	Date of birth:	
Contact information:	Date of assessment:	
Medical history		

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:
P Naco
B. Nose
B. Nose Procedure: Examine the external nose for drainage, obstructions, or any visible deformities.
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C. Oral cavity
Procedure: Evaluate the oral cavity, including the tongue, uvula, and throat. Look for lesions, abnormal positions, and tonsil enlargement.
Documentation:
D. Neck
Procedure: Visually inspect the neck for asymmetry, masses, deformities, or tracheal deviation.
Documentation:
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:
B. Lymph nodes
Procedure: Systematically palpate the lymph node groups for size, tenderness, or irregularities.
Documentation:
C. Cervical spine
Procedure: Palpate the cervical spine and surrounding muscles to detect any pain, spasms, or masses.
Documentation:

A. Cranial nerve evaluation Procedure: Test facial sensation and motor function by assessing movements and responses. Documentation: B. Swallowing assessment Procedure: Observe the patient's ability to swallow, noting any difficulties or abnormal patterns. Documentation: C. Speech evaluation Procedure: Assess the clarity and articulation of the patient's speech during conversation. Documentation: Documentation: Documentation: E. Ear inspection Procedure: Inspect the external ears for any abnormalities, discharge, or deformities. Documentation:	III. Additional assessments
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Results and summary of findings

I. Inspection and palpation summary	
II Additional accessments arranged	
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Additional notes	
Healthcare professional information	
Name:	_ License ID number:
Signature:	Date: