Stroke Assessment Scale

Patient' Name: _____

Examiner's Name: _____

Date of Assessment: _____

No.	Assessment Item	Score	Notes/Remarks
1.	Level of consciousness	____ /5	
2.	Gaze & eye movement	____ /2	
3.	Facial palsy (droopiness)	____ /2	
4.	Motor function - Arm (right)	____ /4	
5.	Motor function - Arm (left)	____ /4	
6.	Motor function - Leg (right)	____ /4	
7.	Motor function - Leg (left)	____ /4	
8.	Sensation (touch, pain, temperature)	____ /2	
9.	Speech clarity (articulation)	____ /2	
10.	Language comprehension & expression	____ /3	
11.	Visual field (vision in all quadrants)	____ /2	
12.	Coordination (finger-nose test, etc.)	____ /2	
13.	Ataxia (walking, balance)	____ /2	
14.	Neglect or inattention (to either side)	____ /2	
15.	Orientation (to person, place, time)	____ /2	
	Total Score	____ /40	

Additional Notes:

Important Note: If you or someone you know is experiencing any of the symptoms listed above or any other unusual symptoms, please seek immediate medical attention. Early intervention is critical in stroke cases. This assessment is only a tool and should not replace a thorough evaluation by a medical professional.