

Introduction to Patient Assessment

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Purpose: Provide a concise, organized reference for students and clinicians beginning the patient assessment process.

1. Why Patient Assessment Matters

Goal	Clinical Impact
Identify health problems early	Prevents complications, reduces morbidity
Establish baseline data	Guides treatment planning & outcome tracking
Prioritize care needs	Supports triage and resource allocation
Communicate with the health?care team	Ensures continuity and safety

2. Core Components of a Comprehensive Assessment

1. Health History (Subjective Data)
 2. Physical Examination (Objective Data)
 3. Functional & Psychosocial Evaluation
 4. Diagnostic Testing (when indicated)
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3. The Health History – “SOAP” Framework

Section	Key Elements	Tips for Gathering Data
S – Subjective	Chief complaint (CC), history of present illness (HPI), review of systems (ROS)	Use open?ended questions, then clarify with focused probes
O – Objective	Vital signs, measurements, observed signs	Record exact numbers; note trends
A – Assessment	Clinical impression, differential diagnoses	Link findings to possible pathophysiology
P – Plan	Immediate actions, further tests, referrals	Keep plan realistic and patient?centered

*Mnemonic for HPI: **OPQRST** (Onset, Provocation/Palliation, Quality, Radiation, Severity, Time)*

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4. Physical Examination – Systematic Approach

1. **General Survey** – Appearance, level of consciousness, distress, hygiene.
2. **Vital Signs** – Temp, pulse, respirations, blood pressure, SpO₂, pain scale.
3. **Head-to-Toe Inspection** – Follow a consistent order (e.g., inspection ? palpation ? percussion ? auscultation).

System	Primary Inspection	Palpation	Percussion	Auscultation
Cardiovascular	Skin color, edema	Pulses, PMI	–	Heart sounds, murmurs
Respiratory	Chest shape, work of breathing	Tactile fremitus	Lung fields	Breath sounds, crackles
Abdominal	Contour, distension	Tenderness, organ size	Tympany vs. dullness	Bowel sounds
Neurologic	Mental status, gait	Muscle tone, reflexes	–	–
Musculoskeletal	Alignment, swelling	Joint stability	–	–

Document any deviations from normal ranges and note laterality.

5. Functional & Psychosocial Assessment

Domain	Assessment Tools / Questions
Activities of Daily Living (ADLs)	Katz Index, Barthel Scale
Instrumental ADLs (IADLs)	Lawton?Brody Scale
Mobility / Fall Risk	Timed Up?and?Go, Morse Fall Scale
Cognition	Mini?Cog, MoCA
Mood / Mental Health	PHQ?9 (depression), GAD?7 (anxiety)
Social Support	Living situation, caregiver availability, community resources
Cultural / Spiritual Needs	Language preference, religious practices, health beliefs

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6. Documentation Essentials

- **Date & Time** of assessment.
- **Patient identifiers** (name, MRN).
- **Source of information** (patient, family, record).
- **Objective measurements** (v