GENERAL

nih stroke scale cheat sheet

Published: September 3, 2026 | Index ID: #-

Introduction

When a patient arrives at the emergency department with sudden neurological symptoms, time is the most valuable resource. Rapid assessment and accurate scoring of the neurological deficit are essential for determining the best therapeutic strategy and improving outcomes. The **National Institutes of Health Stroke Scale (NIHSS)** is the gold standard tool for quantifying the severity of a stroke. However, its 15 items can be daunting for clinicians who need to make quick, reliable decisions. That's why many healthcare professionals rely on a **NIH Stroke Scale cheat sheet**—a concise reference that streamlines the scoring process while ensuring consistency and accuracy.

In this comprehensive guide, we'll explore the NIHSS in depth, explain why a cheat sheet matters, provide a detailed cheat sheet you can print or keep on your device, and offer practical tips for using it in real world scenarios. By the end, you'll have a reliable resource that can help you deliver faster, more precise stroke care.

What Is the NIH Stroke Scale?

The NIH Stroke Scale is a 15 item assessment that evaluates a patient's level of consciousness, vision, facial movement, arm and leg strength, sensation, speech, and language. Each item is scored from 0 (normal) to a maximum value that reflects the degree of impairment. The total score ranges from 0 to 42, with higher scores indicating more severe neurological deficits.

NIHSS was developed in 1988 and is widely used by clinicians, researchers, and stroke registries worldwide. It provides a standardized language for describing stroke severity, facilitates communication across teams, and informs decisions about thrombolysis, thrombectomy, and other interventions.

Why a Cheat Sheet Is Useful

- Speed. In an emergency setting, every second counts. A cheat sheet allows clinicians to quickly reference scoring criteria without searching through manuals.
- Consistency. Uniform scoring across providers reduces inter rater variability and improves the reliability of clinical decisions.
- Training. New residents, nurses, and allied health staff can learn the scale faster when they have a clear, visual reference.
- Documentation. A cheat sheet can serve as a quick audit tool to ensure all items were assessed and scored correctly before charting.

Components of the NIHSS

The NIHSS is divided into two main sections: **Level of Consciousness (LOC)** and **Neurological Deficit**. Each section contains specific items that assess distinct aspects of brain function.

Level of Consciousness

1. Level of Consciousness: Alert
2. Level of Consciousness: Questions
3. Level of Consciousness: Commands

Neurological Deficit

1. Best Gaze
2. Visual Fields
3. Facial Palsy
4. Motor Arm (Right)
5. Motor Arm (Left)
6. Motor Leg (Right)
7. Motor Leg (Left)
8. Limb Ataxia
9. Sensory
10. Best Language
11. Dysarthria
12. Extinction and Inattention

Detailed NIH Stroke Scale Cheat Sheet

Below is a printable cheat sheet you can keep on your desk or embed in a tablet app. Each item includes the scoring range and key points to remember.

1. Level of Consciousness: Alert (LOC1)

Score 0: Fully alert, oriented, and responsive.

Score 1: Alert but not fully oriented or slightly confused.

2. Level of Consciousness: Questions (LOC2)

Ask the patient simple questions (e.g., “What is your name?”).

Score 0: Answers correctly.

Score 1: Answers incorrectly or is confused.

Score 2: Unable to answer.

3. Level of Consciousness: Commands (LOC3)

Ask the patient to perform a simple task (e.g., “Open your hand.”).

Score 0: Executes the command correctly.

Score 1: Executes incorrectly.

Score 2: Does not execute.

4. Best Gaze (Gaze)

Observe spontaneous eye movements.

- Score 0: Normal gaze.
- Score 1: Convergence weakness or mild deviation.
- Score 2: Incomplete or absent gaze deviation.
- Score 3: Complete gaze palsy.

5. Visual Fields (Visual)

Check for homonymous hemianopia.

- Score 0: No visual field loss.
- Score 1: Partial loss.
- Score 2: Complete loss.

6. Facial Palsy (Facial)

Ask the patient to smile or raise eyebrows.

- Score 0: Normal facial movement.
- Score 1: Mild asymmetry.
- Score 2: Moderate asymmetry.
- Score 3: Severe asymmetry or complete paralysis.

7-8. Motor Arm (Right & Left) (Motor)

Ask the patient to lift both arms against resistance.

- Score 0: Full strength.
- Score 1: Mild weakness.
- Score 2: Moderate weakness.
- Score 3: Severe weakness.
- Score 4: No movement.
- Score 5: No movement with resistance.

9-10. Motor Leg (Right & Left) (Motor)

Ask the patient to flex the knees against resistance.

- Score 0: Full strength.
- Score 1: Mild weakness.
- Score 2: Moderate weakness.
- Score 3: Severe weakness.
- Score 4: No movement.
- Score 5: No movement with resistance.

11. Limb Ataxia (Ataxia)

Observe finger to nose or heel to shin movements.

- Score 0: No ataxia.
- Score 1: Mild ataxia.
- Score 2: Moderate ataxia.
- Score 3: Severe ataxia.

12. Sensory (Sensory)

Test light touch or pinprick on both sides.

- Score 0: Normal sensation.
- Score 1: Mild sensory loss.
- Score 2: Moderate sensory loss.
- Score 3: Severe sensory loss.

13. Best Language (Language)

Ask the patient to name common objects.

- Score 0: Normal language.

- Score 1: Mild aphasia.
- Score 2: Moderate aphasia.
- Score 3: Severe aphasia.
- Score 4: Complete aphasia.

14. Dysarthria (Dysarthria)

Listen to speech clarity.

- Score 0: Normal speech.
- Score 1: Mild dysarthria.
- Score 2: Moderate dysarthria.
- Score 3: Severe dysarthria.

15. Extinction and Inattention (Extinction)

Test for neglect by presenting simultaneous stimuli.

- Score 0: No neglect.
- Score 1: Mild neglect.
- Score 2: Moderate neglect.
- Score 3: Severe neglect.

How to Use the Cheat Sheet in Clinical Settings

Using the cheat sheet effectively involves a systematic approach. Here's a step by step workflow:

1. Prepare. Keep the cheat sheet within arm's reach—on a clipboard, a tablet, or a laminated card.
2. Start with LOC. Quickly assess alertness, question response, and command following. These items are fast and set the foundation for the rest of the assessment.
3. Proceed to the neurological deficit section. Work through each item in the order listed above. This ensures no component is missed.
4. Record scores. Write the score next to each item on your assessment sheet or enter it directly into the electronic health record.
5. Calculate the total score. Sum the individual scores; a total of 0–4 indicates a minor stroke, 5–15 moderate, 16–20 severe, and 21–42 very severe.
6. Interpret. Use the total score to guide treatment decisions: eligibility for thrombolysis, need for mechanical thrombectomy, or admission to a specialized stroke unit.
7. Document. Include the total NIHSS score and the date/time of assessment in the patient's chart.

Common Mistakes to Avoid

- Skipping items. Missing a single component can underestimate stroke severity.
- Inconsistent scoring. Use the cheat sheet to standardize your approach across shifts.
- Over reliance on memory.
- Failing to reassess after 24–48 hours.

Tips for Accurate Scoring

- Practice. Simulate stroke scenarios with colleagues to refine your assessment speed.
- Use a stopwatch. Time yourself to ensure you can complete the NIHSS within 5–7 minutes.
- Check for bias. Be aware of language barriers or hearing impairments that may affect speech evaluation.
- Collaborate. Have a nurse or allied health professional confirm sensory and motor findings when possible.

- Document changes. Note any improvement or deterioration to track response to therapy.

Practical Scenarios

Below are two brief case studies illustrating how the cheat sheet can be applied in practice.

Case 1: Rapid Thrombolysis Decision

A 68 year old man presents with sudden right hand weakness and speech difficulty. Using the cheat sheet, you score:

- LOC: 0
- Best Gaze: 1
- Visual Fields: 0
- Facial: 2
- Motor Arm (Left): 4
- Motor Arm (Right): 0
- Motor Leg (Left): 0
- Motor Leg (Right): 0
- Limb Ataxia: 0
- Sensory: 1
- Best Language: 3
- Dysarthria: 1

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