



Checklist for On-Site Examination of Head Injury

Primary Survey

- ☐ Check the surroundings and environment and gain a history of the event as necessary from bystanders if you did not witness.

When you reach the injured person, establish level of consciousness by checking the following:

- ☐ Eye opening
- ☐ Verbal response
- ☐ Motor response

If patient is unconscious, immediately do the following:

- ☐ Examine in the position found.
- ☐ Check airway, breathing, and pulse (rate, rhythm, strength), and take blood pressure.
- ☐ Observe and control severe bleeding.
- ☐ Observe for lateralizing signs and evidence of decorticate or decerebrate posturing.
- ☐ Examine pupillary reflexes.
- ☐ Observe for shock (signs and symptoms opposite those of intracranial hemorrhage).

It is of utmost importance that you do the following:

- ☐ Assume cervical spine injury until proven otherwise.
- ☐ Summon EMS if you note any positive signs.
- ☐ Reexamine vital signs every 5 minutes.

Secondary Survey

History

If patient is conscious, ask questions pertaining to the following:

- ☐ Mechanism of injury
- ☐ Loss of consciousness
- ☐ Location, type, and severity of symptoms
- ☐ Unusual sensations (tinnitus, dizziness, headache)
- ☐ Complaints of cervical pain or any radiating symptoms into extremities
- ☐ Orientation to time, person, place, and self

Observation

- ☐ Unusual body movements or behavior
- ☐ Unusual facial expressions (drooling, drooping of one eyelid or corner of mouth)

- ☐ Level of consciousness (alert, restless, lethargic)
- ☐ Pupils for size, equality, and reaction to light
- ☐ Unusual eye movements (nystagmus, cross-eye, or lateral drift)
- ☐ Otorrhea, rhinorrhea
- ☐ Swelling, deformity, bleeding, or discoloration (Battle's sign, raccoon eyes)
- ☐ Continue monitoring vital signs (pulse, respiration, blood pressure, level of consciousness).

Palpation

- ☐ Face and skull for tenderness, swelling, deformity, or depressions
- ☐ Cervical spine for tenderness, swelling, and deformity (as indicated)

Neurological Tests

- ☐ Upper motor neuron lesions tests (table 8.4 in chapter 8)
- ☐ Cranial nerve check (table 19.1)
- ☐ Cervical spine check
- ☐ Active ROM of all four extremities
- ☐ Grip strength and dorsiflexion strength

Periodic Reevaluation

Continue to monitor vital signs every 5 minutes, and refer immediately for any of the following:

- ☐ Decreasing level of consciousness
- ☐ Declining mental status
- ☐ Increasing blood pressure
- ☐ Decreasing or irregular pulse (decrease, irregular)
- ☐ Decreasing or irregular respirations
- ☐ Unequal, dilated, or unreactive pupil(s)
- ☐ Worsening headache
- ☐ Numbness in the arms or legs
- ☐ Repeated vomiting
- ☐ Seizures
- ☐ Slurred speech or inability to speak

If the patient is stable and there are no signs of serious head injury, the patient can be transported off-site with assistance as needed for a more thorough examination on the sideline.