

Conscious Head Injury Evaluation

1. Survey scene: Posturing
2. Stabilize
3. CABs and vitals
4. History (brief)
5. Observation
 - a. Brief and obvious
 - b. Signs of distress
 - i. Facial expressions, speech patterns, emotional state
 - ii. Look for other signs of more serious injury
 1. Rhinorrhea
 2. Otorrhea
 3. Nystagmus
 4. Battle signs
 5. Raccoon eyes
6. LOC: AVPU and/or Glasgow coma scale
7. Palpation: General for soft spots or bumps
8. Other S/S
 - a. Vacant stare
 - b. Delayed motor responses
 - c. Slurred speech
 - d. Heightened emotions
 - e. Memory deficits (retrograde/anterograde)
 - f. Headache
 - g. Tinnitus
 - h. Inability to concentrate
 - i. Disorientation
 - j. Gross incoordination
 - k. Nausea/vomiting
 - l. Fatigue
 - m. Dizziness/vertigo
 - n. Lightheadedness
9. Recheck vitals
10. Moving the patient: Decide if possible and determine preferred method
11. Motor and sensory evaluation
 - a. Motor: Palpate area for tone; perform PROM for tone
 - b. Sensory: Basic sensory testing
 - c. Reflex: UE & LE
 - d. Neurological control tests
 - e. Balance: Tandem or stork standing, tandem walking
 - f. Coordination and proprioception
 - i. Finger tap test
 - ii. Heel to knee
 - iii. Hand to thigh
 - iv. Finger/nose
 - v. Finger to thumb
 - vi. Past pointing
12. Cognitive testing
 - Serial sevens
 - Three objects
 - Simple directions
13. Return to play guidelines