



Health Assessment and Physical Examination

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Health Assessment

Healthy Person, Client

Skills  Nurses' **clinical** expertise

First Phase in Nursing Process (Vital Steps)  **ADPIE**

Purposes of Health Assessment

- A systematic and objective Method of evaluating the patient' health status
- Data collection  analysis
- Nursing Diagnosis  Making decision to patient care

Any assessment involves collecting two kinds of data:

- Objective data (signs)  Observation by nurse



Any assessment involves collecting two kinds of data:

- Subjective data (symptoms):  Obtained from client

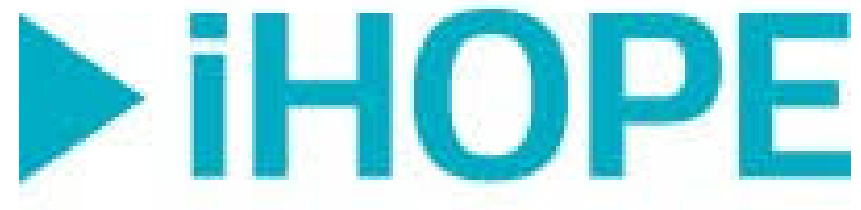


- Major steps to assessment
- Sources for data collection



The process of assessing a patient's health includes:

- I → Interview
- H → History
- O → Observation
- P → Physical
- E → Examination



Exploring the Chief Complaint (cc):

P → Provoke or Palliative

Q → Quality or Quantity

R → Region or Radiation

S → Severity

T → Timing



COLDSPA

C

Character

O

Onset

L

Location

D

Duration

S

Severity

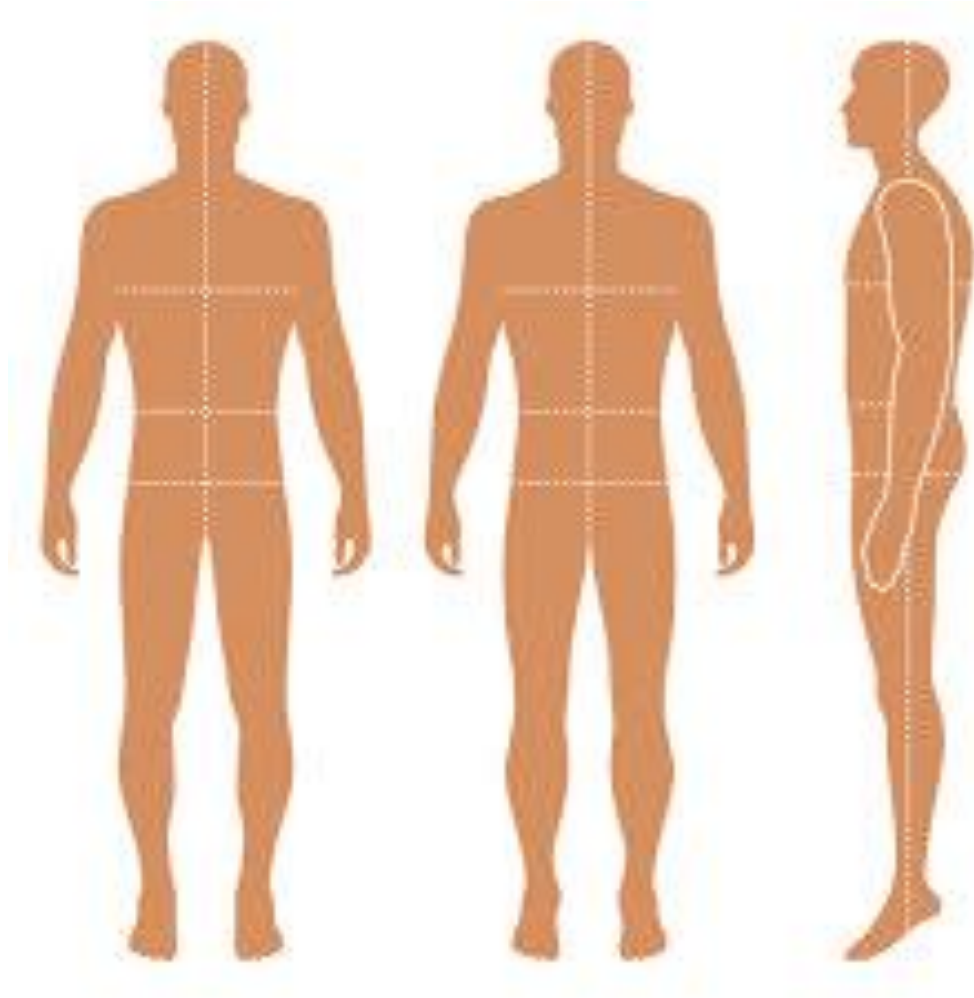
P

Pattern

A

Associated Factors

Physical Examination (Review of Body System)



Four basic techniques in assessment and physical examination

1



Inspection

HEAD-to-TOE

Assessment Techniques

4



Auscultation

2



Palpation

3



Percussion

Inspection

Visual Examination of the client (eyes, smell, and hear)



Palpation

Uses the sense of touch



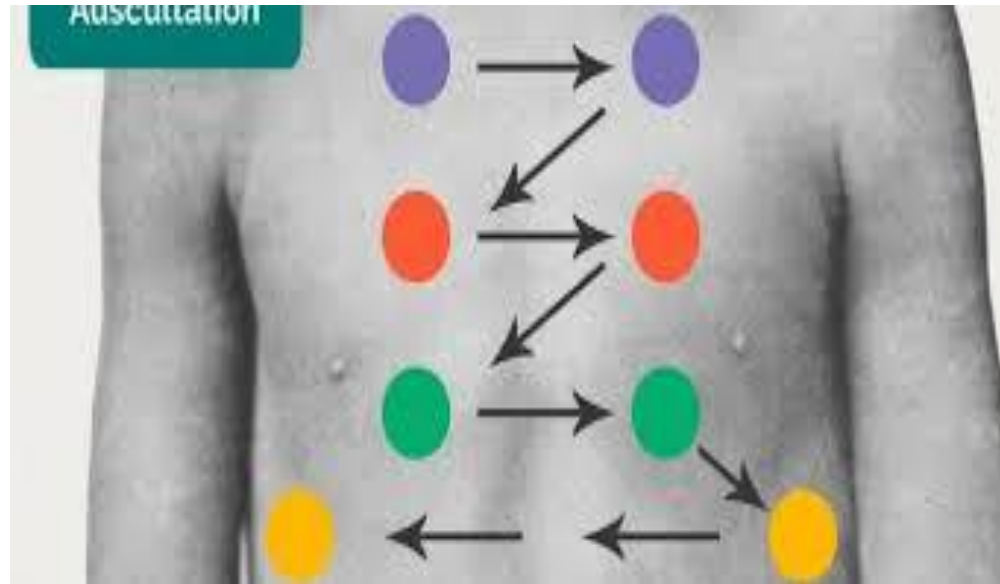
Percussion

- Striking of the body surface



Auscultation

Listening with a stethoscope



General Appearance & Vital Signs

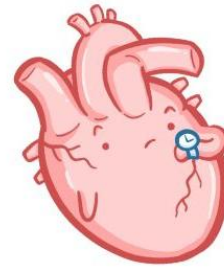
Vital Signs - Overview



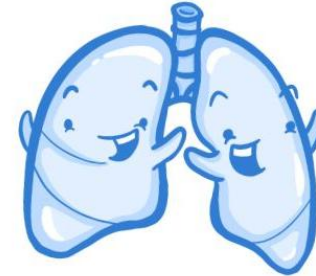
**BODY
TEMPERATURE**



**BLOOD
PRESSURE**



**HEART RATE
(PULSE)**



**RESPIRATORY
RATE**



**OXYGEN
SATURATION**



PAIN

Pain

- Assess using scales (0–10, Wong-Baker)

Wong-Baker FACES Pain Rating Scale



Pain Assessment

WHATSUP method include-

- ✓ **W**- where is the pain? Be specific. Use drawing of body if necessary.
- ✓ **H** – how does the pain feel? Is it shooting, burning, dull, sharp?
- ✓ **A** – aggravating and alleviating factors. What makes the pain better? Worse?
- ✓ **T** – timing. When did the pain start? Is it intermittent? Continuous?
- ✓ **S** – severity. How bad is the pain on a 0 to 10 faces scale.
- ✓ **U** – useful other data. Are you experiencing any other symptoms associated with the pain or pain treatment? Itching, nausea, sedation, constipation?
- ✓ **P** – perception. What is the client's perception of what caused the pain?

Pain

Acute vs. Chronic Pain

	Acute Pain	Chronic Pain
Onset	Usually sudden	Long duration
Characteristics	Sharp, localized, may radiate	Dull, aching, persistent, diffuse
Signs and Symptoms	Autonomic response Hyperactivity Emotional response Anxiety, restlessness	Autonomic response Often absent Emotional response Flat, depressed