HEAD TO TOE ASSESSMENT

Name _____

Description _____

Chief Complaint _____

Sex ____ Age ____ Mech Inj _____

S=Satisfactory U=Comment Below

Time of Assessment	:	:	:	:
Head				
Neck				
Shoulders				
Chest				
Arms				
Abdomen				
Pelvis				
Legs				
Back				
Mental Status				
CERT Initials				

Symptoms:_____

_____

_____

PATIENT HISTORY

Address _____

Phone _____

Contact Name _____

Contact Phone _____

Physician _____ City_____

Last Oral Intake _____
Allergies – Food _____
Allergies – Drug _____
Medications _____
Asthma/Lung _____
Back Pain _____
Cancer _____
Cardiac _____
Diabetes _____
Eye Glasses _____
Seizures _____
Stroke _____
History _____

_____

_____

Taken By _____

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