

NIH Stroke Scale (NIHSS)

Item	Options	Points
1a. Level of consciousness	Alert: Keenly responsive	0
	Not alert, arousable: Wakes to minor stimulation and obeys or answers	1
	Not alert, obtunded: Needs repeated or painful stimulation to respond	2
	Unresponsive: Reflex motor responses only, or totally unresponsive and flaccid	3
1b. LOC questions (month and age)	Both correct: Answers both questions correctly	0
	One correct: Answers one question correctly	1
	Neither correct: Answers neither question correctly	2
1c. LOC commands	Both correct: Performs both tasks correctly	0
	One correct: Performs one task correctly	1
	Neither correct: Performs neither task correctly	2
2. Best gaze	Normal: Full horizontal eye movements	0
	Partial gaze palsy: Gaze abnormal in one or both eyes, no forced deviation	1
	Forced deviation: Or total gaze paresis not overcome by oculoccephalic maneuver	2
3. Visual fields	No visual loss	0
	Partial hemianopia: Includes quadrantanopia or clear-cut asymmetry	1
	Complete hemianopia	2
	Bilateral hemianopia: Blind from any cause, including cortical blindness	3
4. Facial palsy	Normal: Symmetrical movements	0
	Minor paralysis: Flattened nasolabial fold, asymmetric smile	1
	Partial paralysis: Total or near-total paralysis of the lower face	2
	Complete paralysis: No movement in upper and lower face, one or both sides	3
5a. Motor arm, left	No drift: Holds for full 10 seconds	0
	Drift: Drifts down before 10 seconds, does not hit bed or support	1
	Some effort against gravity: Cannot reach or keep position, drifts to bed	2
	No effort against gravity: Limb falls	3
	No movement	4
5b. Motor arm, right	No drift: Holds for full 10 seconds	0
	Drift: Drifts down before 10 seconds, does not hit bed or support	1
	Some effort against gravity: Cannot reach or keep position, drifts to bed	2
	No effort against gravity: Limb falls	3
	No movement	4
6a. Motor leg, left	No drift: Holds 30 degrees for full 5 seconds	0
	Drift: Falls by the end of 5 seconds but does not hit bed	1
	Some effort against gravity: Falls to bed by 5 seconds	2
	No effort against gravity: Falls to bed immediately	3
	No movement	4

Item	Options	Points
6b. Motor leg, right	No drift: Holds 30 degrees for full 5 seconds	0
	Drift: Falls by the end of 5 seconds but does not hit bed	1
	Some effort against gravity: Falls to bed by 5 seconds	2
	No effort against gravity: Falls to bed immediately	3
	No movement	4
7. Limb ataxia	Absent	0
	Present in one limb	1
	Present in two limbs	2
8. Sensory	Normal: No sensory loss	0
	Mild to moderate loss: Pinprick less sharp or dull, but aware of touch	1
	Severe to total loss: Not aware of being touched on face, arm and leg	2
9. Best language	No aphasia: Normal	0
	Mild to moderate aphasia: Some loss of fluency or comprehension, meaning still clear	1
	Severe aphasia: Fragmentary expression, listener carries the burden	2
	Mute, global aphasia: No usable speech or auditory comprehension	3
10. Dysarthria	Normal	0
	Mild to moderate: Slurs some words, can be understood with some difficulty	1
	Severe: Unintelligible out of proportion to any aphasia, or mute	2
11. Extinction and inattention	No abnormality	0
	Mild inattention: Extinction or inattention in one sensory modality	1
	Profound hemi-inattention: In more than one modality, or does not recognize own hand	2

Interpretation

0	No stroke symptoms. No measurable deficit on the NIHSS. A normal score does not rule out stroke, especially posterior circulation stroke, so keep assessing if symptoms persist.
1-4	Minor stroke. Mild deficits. Treat it as a stroke until proven otherwise: activate your stroke protocol and watch closely, because a low score can still hide a disabling deficit.
5-15	Moderate stroke. Clear neurological deficits. Follow your stroke pathway without delay, repeat the NIHSS at the intervals your protocol sets and report any rise promptly.
16-20	Moderate to severe stroke. Major deficits that suggest a large area of brain injury. Expect close monitoring of airway, swallowing and neuro status, and escalate any worsening right away.
21-42	Severe stroke. Severe, widespread deficits. Prioritize airway protection, aspiration precautions and frequent neuro checks, and keep the provider informed of every change.

Total score: _____ Date: _____ Assessed by: _____

Brott, Adams, Olinger et al., 1989 (National Institute of Neurological Disorders and Stroke). Sources: NINDS: NIH Stroke Scale (official form); Brott et al. 1989, Stroke: original NIHSS article; Kogan et al. 2020, BMC Med Inform Decis Mak: NIHSS severity categories; Cleveland Clinic: NIH Stroke Scale. Free calculator and full guide: nursingscales.com/nih-stroke-scale/ · Educational material; does not replace clinical judgment or facility protocols.