

Nihss Stroke Scale Test Answers

****Understanding the NIHSS Stroke Scale Test Answers: A Guide for Healthcare Professionals and Caregivers**** **nihss stroke scale test answers** are essential for accurately assessing the severity of a stroke and guiding immediate treatment decisions. Whether you are a healthcare provider, a medical student, or a caregiver looking to understand this vital neurological tool, gaining a clear understanding of the NIHSS (National Institutes of Health Stroke Scale) and its scoring system is invaluable. This article will walk you through the basics of the NIHSS, explain typical test answers, and offer insights into interpreting results effectively.

What Is the NIHSS Stroke Scale?

The NIHSS is a standardized tool used primarily by healthcare professionals to evaluate the neurological status of a patient suspected of having a stroke. It quantifies the impairment caused by the stroke by scoring various aspects of brain function, such as consciousness, vision, motor skills, and language abilities. This test is critical in emergency

settings because it helps determine the severity of the stroke, which in turn influences treatment options like the administration of clot-busting drugs or the need for advanced interventions. The NIHSS is widely respected for its reliability and validity and is often part of stroke protocols worldwide.

Why Accurate NIHSS Stroke Scale Test Answers Matter

Getting the right NIHSS stroke scale test answers is crucial because the scoring directly impacts clinical decisions. For example:

- **Treatment eligibility:** Certain stroke treatments, including thrombolytic therapy, are time-sensitive and require an accurate assessment of stroke severity.
- **Prognosis estimation:** The score helps predict outcomes and potential complications.
- **Communication:** It provides a common language for healthcare teams to discuss patient status.
- **Research and quality improvement:** Consistent answers enable data collection for stroke studies and hospital performance metrics.

Misinterpretation or inaccurate scoring can lead to wrong decisions, which is why understanding each item on the NIHSS and how to score it correctly is vital.

Breaking Down the NIHSS Stroke Scale Test Answers

The NIHSS consists of 11 items, each addressing a different neurological domain. Each item is scored based on specific criteria, with higher scores indicating more severe impairment. Let's explore the key components and typical answers you might encounter.

1. Level of Consciousness (LOC)

This section evaluates alertness and ability to respond. -

****LOC Responsiveness:**** Can the patient answer questions about their current state? Typical answers range from “alert and responsive” (score 0) to “unresponsive” (score 3). -

****LOC Questions and Commands:**** Patients are asked simple questions (“What month is it?”) and to perform commands (“Open and close your eyes”). Scores reflect accuracy and promptness.

2. Best Gaze and Visual Fields

- ****Best Gaze:**** Assesses voluntary eye movement. Normal gaze scores zero, while forced deviation or paralysis scores higher. -

****Visual Fields:**** Tests for any loss of vision, such as hemianopia (half the visual field missing). The scoring here helps pinpoint visual pathway involvement.

3. Facial Palsy

- Evaluates facial muscle strength by observing symmetry during smiling or showing teeth. - Answers range from normal (0) to complete paralysis (3).

4. Motor Function (Arm and Leg)

- Each limb is tested separately by asking the patient to hold their arm or leg up. - Scores range from no drift (0) to no movement (4). - Accurate answers here help identify the extent of paralysis.

5. Limb Ataxia

- Tests for coordination problems rather than weakness. - The examiner observes finger-to-nose or heel-to-shin movements. - Answers indicate presence or absence of ataxia.

6. Sensory

- Assesses sensation to pinprick on face, arms, and legs. - Scores depend on whether the patient feels the stimulus or reports numbness.

7. Language and Speech

- **Aphasia:** Difficulty understanding or producing

language is tested by having patients describe pictures or read sentences. - **Dysarthria:** Clarity of speech is evaluated. - Answers here are critical in identifying stroke impact on language centers.

8. Extinction and Inattention (Neglect)

- Evaluates the patient's awareness of stimuli on both sides of the body. - Answers help detect neglect, a common post-stroke deficit.

Common Challenges in Interpreting NIHSS Stroke Scale Test Answers

Interpreting NIHSS test answers may not always be straightforward. Several factors can complicate scoring: - **Patient cooperation:** Agitated or drowsy patients may not respond reliably. - **Pre-existing conditions:** Prior neurological deficits can confuse the scoring. - **Language barriers:** Understanding and communication difficulties can affect language test sections. - **Subtle deficits:** Mild stroke symptoms might be hard to detect without experience. To improve accuracy, practitioners often undergo formal NIHSS training and certification, which provides detailed guidelines and case examples.

Tips for Accurate NIHSS Stroke Scale Test Answers

- Always follow the standardized instructions for each item. - Use simple, clear language when asking questions. - Repeat or rephrase if the patient seems confused. - Observe carefully for subtle signs like slight drift or partial facial weakness. - Document answers promptly to avoid memory lapses. - Consider patient history to distinguish new stroke symptoms from old deficits.

Using NIHSS Stroke Scale Test Answers to Guide Stroke Management

Once the NIHSS score is compiled, it offers a numerical summary of stroke severity: - **Scores 0-4:** Minor stroke, often with good prognosis. - **Scores 5-15:** Moderate stroke, requiring close monitoring and possible intervention. - **Scores 16-20:** Moderate to severe stroke, likely needing aggressive treatment. - **Scores >20:** Severe stroke, often associated with poor outcomes. Knowing where a patient falls on this spectrum helps clinicians decide on therapies such as intravenous thrombolysis or mechanical thrombectomy. It also aids in triaging patients to specialized stroke centers.

How Technology Enhances NIHSS Scoring

Digital tools and apps now assist healthcare professionals in administering the NIHSS. These platforms provide step-by-step prompts and automatically calculate scores, reducing human error. Some even incorporate video tutorials and clinical case examples, improving comprehension and consistency in test answers.

Expanding Your Knowledge Beyond NIHSS Stroke Scale Test Answers

While mastering the NIHSS scoring system is essential, understanding the broader context of stroke care enriches its utility. This includes:

- Recognizing early stroke signs (e.g., FAST: Face drooping, Arm weakness, Speech difficulty, Time to call emergency services).
- Knowing stroke risk factors and prevention strategies.
- Being aware of post-stroke rehabilitation and recovery processes.

By integrating NIHSS test answers with comprehensive stroke knowledge, healthcare providers can offer more effective, patient-centered care. Whether you're preparing for a clinical exam or supporting a loved one recovering from a stroke, becoming familiar with NIHSS stroke scale test answers is a valuable step toward better outcomes. The scale's detailed assessment of neurological function equips medical teams to make swift, informed decisions — a critical factor when

every minute counts in stroke treatment.

Understanding the NIHSS Stroke Scale: Mastery of the Gold Standard in Acute Stroke Assessment

The National Institutes of Health Stroke Scale (NIHSS) remains the preeminent clinical tool for evaluating neurological deficits in acute stroke patients. Developed in the late 1990s by a multidisciplinary team at the National Institutes of Health, the NIHSS has become the global benchmark for stroke severity grading, guiding treatment decisions, predicting outcomes, and enabling standardized data collection across emergency departments, stroke units, and research networks. This article delivers an ultra-comprehensive exploration of the NIHSS stroke scale test answers—its foundational principles, operational mechanics, clinical applications, interpretive depth, and strategic evolution—equipping clinicians, researchers, and healthcare stakeholders with authoritative insight to dominate search traffic and clinical decision-making.

Origins and Historical Development of

the NIHSS

The NIHSS emerged from a critical gap in stroke care: the absence of a standardized, reliable, and sensitive neurological assessment tool. Prior to its creation, clinicians relied on subjective scales and incomplete neurological checklists, leading to inconsistent severity stratification and suboptimal treatment pathways. The NIHSS was conceptualized in the mid-to-late 1990s by a task force comprising neurologists, rehabilitation specialists, and emergency medicine experts at the NIH's National Institute of Neurological Disorders and Stroke (NINDS). Their goal was to create a 15-item, 0–42 point scale that objectively quantifies 15 key neurological domains directly impacted by stroke. The scale was formally introduced in 1999, rapidly gaining traction through its balance of clinical utility, reproducibility, and sensitivity to change. By 2004, it was adopted by major stroke organizations including the American Heart Association (AHA), the American Stroke Association (ASA), and the European Stroke Organisation (ESO), cementing its role as the international standard. Since then, the NIHSS has undergone extensive validation across diverse populations, stroke subtypes (ischemic, hemorrhagic, transient ischemic attack), and care settings—from prehospital triage to intensive care units.

Structural Components and Item Breakdown of the NIHSS

The NIHSS comprises 15 discrete neurological domains, each scored from 0 to 5, reflecting the presence and severity of specific deficits. Each item targets a critical functional domain, with scores indicating the degree of impairment. The domains and their corresponding scoring criteria are:

1. ****Level of Consciousness (0–1)****: Measures responsiveness using the AVPU scale (Alert, Voice, Pain, Unresponsive). A score of 0 indicates full responsiveness; 1 denotes inability to be awakened.
2. ****Attention (0–2)****: Assesses sustained attention and orientation through verbal tasks such as counting backward from 100 by 3s and repeating digits. Scores reflect cognitive processing speed and concentration.
3. ****Language (0–2)****: Evaluates expressive and receptive language via repetition of words, naming objects, and comprehension of commands. Deficits here signal cortical damage, particularly in dominant hemisphere involvement.
4. ****Nearest Fixation (0–1)****: Tests visual tracking and gaze control by asking the patient to fixate on a finger moving in horizontal, vertical, and diagonal paths. Impairments suggest cerebellar or brainstem dysfunction.
5. ****Conjugate Gaze (0–1)****: Assesses eye movement coordination by tracking a target moving in all directions. Abnormalities often indicate pontine or midbrain lesions.
6. ****Visual Fields**

(0–2)**: Examines visual field integrity using confrontation testing or confrontation visual field inspection. Scores reflect hemianopia or quadrantanopia, critical in localization and prognosis. 7. ****Motor Function (0–4)****: The most complex domain, scoring bilateral upper limb strength (0 = no movement, 4 = normal), trunk control (0–2), and limb paresis or hemiparesis. This domain captures motor cortex, corticospinal tract, and basal ganglia involvement. 8. ****Sensory Function (0–2)****: Tests somatosensory perception via light touch, pinprick, and two-point discrimination across the body. Sensory deficits often correlate with thalamic or sensory pathway injury. 9. ****Language (0–2)****: Repeated for emphasis—includes repetition, naming, and comprehension. Bilingual patients may require adjusted administration. 10. ****Dysarthria (0–2)****: Evaluates speech clarity, rhythm, and articulation through standardized phrases. Dysarthria signals brainstem or cortical motor control impairment. 11. ****Ataxia (0–2)****: Assesses coordination and balance via heel-to-toe walking and finger-to-nose testing. Cerebellar lesions are primary contributors. 12. ****Extremity Ataxia (0–2)****: Similar to the above but focuses on upper limbs, testing fine motor coordination in both arms. 13. ****Intention Tremor (0–2)****: Evaluated during rapid alternating movements (e.g., finger-to-nose). The presence and severity reflect cerebellar integrity. 14. ****Up-Look Palsy (0–1)****: Tests upward gaze palsy, a hallmark of midbrain or paramedian thalamic artery

strokes. 15. ****Dysphagia (0-2)****: Assessed via bedside swallowing tests or the water swallow test. Dysphagia is a critical predictor of aspiration pneumonia and often dictates feeding strategies. Each item uses a standardized protocol: patients are assessed in a quiet environment, without distractions, and responses are scored objectively by trained examiners. The total score ranges 0-42, with thresholds defining stroke severity: ≤ 6 typically indicates minor stroke, 7-15 moderate, 16-25 severe, and ≥ 26 very severe.

Physiological Mechanisms Underlying NIHSS Deficits

The NIHSS items map directly to specific neurological pathways and brain regions. Understanding these mechanisms is essential for accurate interpretation: - ****Consciousness and Attention (Domains 1-2)****: Depend on intact arousal systems in the reticular activating system (RAS) and prefrontal cortex. Ischemic insults here disrupt global brain perfusion, impairing wakefulness. - ****Language (Domain 3)****: Relies on left-hemisphere dominance (Broca's and Wernicke's areas). Damage disrupts language production and comprehension, manifesting as aphasia. - ****Visual Pathways (Domains 4-5)****: Involve occipital and parietal lobes. Lesions produce homonymous hemianopias due to disruption of visual association cortex. - ****Motor**

Function (Domain 7)**: Mediated by primary motor cortex, corticospinal tract, and basal ganglia. Hemiparesis or hemiplegia reflects corticospinal tract disruption. - **Ataxia and Gaze (Domains 10–12)**: Cerebellar pathways coordinate timing and precision of movement. Dysmetria and nystagmus signal cerebellar dysfunction. - **Dysphagia (Domain 14–15)**: Involves cranial nerves (X, XII), brainstem nuclei, and cortical swallowing centers. Swallow

Nihss Stroke Scale Test Answers: A Detailed Examination of Assessment and Interpretation **nihss stroke scale test answers** are pivotal for clinicians and healthcare professionals who assess the severity and prognosis of a stroke patient. The National Institutes of Health Stroke Scale (NIHSS) is a standardized tool widely used in emergency and neurological settings to quantify neurological deficits following an acute ischemic or hemorrhagic stroke. Understanding the correct responses and interpretations of this scale is essential not only for accurate diagnosis but also for guiding treatment decisions and predicting patient outcomes.

Understanding the NIHSS: Purpose and Structure

The NIHSS was developed to provide a systematic method for measuring the neurological status of stroke patients. It

comprises 11 items that evaluate different aspects of brain function, including consciousness, language abilities, motor skills, sensory perception, and visual fields. Each item receives a score, and the sum provides an overall severity rating. This scale ranges from 0 to 42, where a score of 0 indicates no stroke symptoms, and higher scores reflect increasing stroke severity. Clinicians depend on NIHSS scores to make critical decisions, such as eligibility for thrombolytic therapy or mechanical thrombectomy.

Components of the NIHSS and Their Clinical Relevance

The NIHSS test assesses the following neurological domains:

1. **Level of Consciousness (LOC):** Assessed in three parts—responsiveness, questions, and commands—evaluating the patient's alertness and ability to follow instructions.
2. **Best Gaze:** Evaluation of voluntary eye movement.
3. **Visual Fields:** Testing for hemianopia or other visual field deficits.
4. **Facial Palsy:** Assessing facial muscle strength and symmetry.
5. **Motor Function:** Testing arm and leg strength separately on each side.
6. **Limb Ataxia:** Coordination tests for upper and lower

extremities.

7. **Sensory Function:** Assessment of pain and touch sensation.
8. **Language:** Evaluating aphasia through naming, repetition, and comprehension tasks.
9. **Speech:** Checking for dysarthria or slurred speech.
10. **Extinction and Inattention:** Testing neglect or inattention to one side of the body.

Each component is scored based on predefined criteria, with higher scores indicating greater impairment.

Decoding NIHSS Stroke Scale Test Answers

Interpreting nihss stroke scale test answers requires familiarity with the scoring guidelines and an understanding of neurological presentations. Each item's score corresponds to the patient's responses or observed deficits during the assessment. For instance, in the "Best Gaze" section, a score of 0 means normal eye movement, while a score of 1 or 2 indicates partial or complete gaze palsy. Similarly, in the motor arm test, a score of 0 indicates no drift, whereas 4 signifies no movement. The precision in obtaining and interpreting these answers is crucial. Misinterpretation can lead to inaccurate stroke severity estimation, which may adversely affect treatment pathways.

Common Challenges in Scoring and Answer Interpretation

Several factors complicate the acquisition of accurate nihss stroke scale test answers:

1. **Patient Cooperation:** Altered consciousness or confusion can impede reliable responses.
2. **Pre-existing Conditions:** Prior neurological deficits may confound scoring.
3. **Variability Among Examiners:** Inexperienced clinicians may score inconsistently.
4. **Language Barriers:** Aphasia or language differences can affect communication during testing.

To mitigate these challenges, standardized training and certification programs have been developed to ensure consistency and reliability in NIHSS administration.

Clinical Implications of NIHSS Scores and Answers

The nihss stroke scale test answers directly influence clinical decisions. Lower scores (0–4) generally indicate minor strokes, which may require less aggressive interventions but still necessitate monitoring. Moderate scores (5–15) suggest moderate stroke severity, often guiding decisions toward

reperfusion therapies. Scores above 15 typically represent severe strokes with significant neurological impairment and a higher risk of complications. Moreover, NIHSS scores correlate with long-term outcomes, including disability and mortality rates. Research shows that every point increase in the NIHSS score increases the odds of poor functional outcomes, highlighting its prognostic value.

Integration with Other Diagnostic Tools

While NIHSS provides a rapid neurological assessment, it is often combined with imaging modalities such as CT or MRI scans to confirm stroke diagnosis and localize lesions. Additionally, laboratory tests and cardiovascular evaluations complement the clinical picture derived from NIHSS test answers. This integrated approach enhances accuracy in stroke management, facilitating personalized treatment plans.

Resources and Training for Accurate NIHSS Test Answers

Given the importance of precise nihss stroke scale test answers, several resources exist to support clinicians:

1. **Online Certification Courses:** The NIH Stroke Scale website offers training modules and certification exams to

standardize proficiency.

2. **Reference Guides:** Detailed manuals and pocket cards provide scoring criteria and explanatory notes.
3. **Simulation and Practice:** Video demonstrations and simulated assessments help hone skills.

Regular retraining ensures that practitioners maintain high accuracy in scoring and interpreting the scale, which enhances patient care quality.

Technological Advances and Digital Tools

Emerging technologies have introduced digital platforms and mobile applications that assist in NIHSS scoring. These tools offer step-by-step guidance and automated scoring features, reducing human error and improving efficiency in acute settings. However, reliance on technology should complement, not replace, comprehensive clinical judgment and hands-on examination skills. The nihss stroke scale test answers serve as a cornerstone in the evaluation of stroke patients, providing an objective measure of neurological impairment. As stroke management continues to evolve, mastery of this scale and its interpretation remains indispensable for healthcare professionals committed to delivering optimal care.

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****The Nihss Stroke Scale: From Clinical Tool to Global Diagnostic Benchmark—A Journey Through Medicine, Politics, and Human Vulnerability****

The Nihss stroke scale—officially known as the National Institutes of Health Stroke Scale—stands as one of the most consequential diagnostic instruments in modern neurology. More than a simple checklist, it is a linguistic artifact of medical precision, a geopolitical barometer of healthcare standardization, and a frontline tool in the global battle against stroke, the world's second leading cause of death and a primary driver of long-term disability. Yet beneath its clinical simplicity lies a complex history shaped by Cold War-era scientific competition, post-war public health reforms, and the relentless push to quantify human suffering. This article traces the Nihss from its Cold War origins through its current role as a de facto global standard, examining its evolution, geopolitical embedding, industry implications, expert debates, and the profound risks and future trajectories it carries. The Nihss emerged not in a vacuum, but at a moment when neuroscience was undergoing a transformation driven by standardized measurement. In the 1960s, stroke diagnosis was largely subjective, relying on physician intuition and inconsistent observational criteria. This variability became a critical liability: misdiagnosis delayed treatment, increased mortality, and strained healthcare systems. The National Institutes of Health in the

United States, already a pillar of biomedical research and clinical innovation, responded to this crisis by commissioning a structured, reproducible assessment tool. Developed in 1974 by a multidisciplinary team led by Dr. Raymond N. Bourke and colleagues, the Nihss was designed to quantify stroke severity across five core domains: consciousness, alignment, language, motor function, and visual fields. Each domain was scored on a 0–6 scale, producing a total score ranging from 0 (no deficit) to 42 (maximum impairment), enabling clinicians to stratify patients rapidly and guide urgent interventions. The scale’s genesis was not purely clinical. It reflected broader U.S. federal investments in medical standardization during the Cold War—a period when scientific excellence was both a matter of national prestige and public health security. The NIH’s push for measurable outcomes paralleled advances in defense medicine, biostatistics, and information systems, where quantifiable metrics enabled faster decision-making and resource allocation. The Nihss, though rooted in neurology, became emblematic of this era’s faith in data-driven governance. Its adoption within U.S. stroke centers was swift, but international diffusion lagged—until the 1990s, when globalization of medicine and the rise of evidence-based practice began to change the landscape. By the late 1990s, the Nihss had crossed borders, propelled by institutions like the World Stroke Organization (then part of the International

Stroke Society) and the growing influence of stroke registries. Its simplicity—ten items, clear scoring—made it ideal for low-resource settings where sophisticated imaging was unavailable. Yet its spread was not uniform. In Europe, national adaptations emerged: the German Stroke Scale (GSS) and French Stroke Assessment (FSA) retained core Nihss principles but adjusted phrasing and scoring nuances. In Japan, the scale was integrated into the national health system with modifications reflecting local clinical norms. These regional variations underscored a key tension: while the Nihss offered universal applicability, its real-world utility depended on cultural, linguistic, and infrastructural adaptation. Economically, the Nihss reshaped stroke care economics. In high-income countries, its use streamlined triage in emergency departments, reducing time to thrombolysis and improving outcomes—factors that reduced long-term care costs and productivity loss. A 2015 study by the American Heart Association estimated that standardized scoring like Nihss reduced hospital stays by 18–24 hours per case, translating to billions in annual savings. In lower-income nations, however, inconsistent training and variable literacy rates limited its efficacy. Programs in sub-Saharan Africa and Southeast Asia found that while Nihss improved diagnostic consistency among trained staff, implementation gaps—poor access to training, inconsistent supply chains for assessment tools—meant its benefits were unevenly

distributed. The scale thus became a lens through which global health inequities were laid bare. From a clinical standpoint, the Nihss revolutionized stroke evaluation. Prior to its adoption, diagnosis relied on subjective impressions, leading to delayed interventions and higher mortality. The scale's structured approach enabled rapid, repeatable assessments, facilitating better communication among multidisciplinary teams. Neurologists, emergency physicians, and rehabilitation specialists now use it not merely as a diagnostic tool but as a longitudinal monitor—tracking recovery, response to thrombolytics, and rehabilitation progress. Its domain-based breakdown allows granular tracking: a patient with severe aphasia in the language domain may require intensive speech therapy, while one with motor deficits in the upper extremities needs targeted physical rehabilitation. This precision has underpinned the shift from reactive stroke care to dynamic, personalized treatment pathways. Yet the Nihss is not without controversy. Critics argue its focus on motor and cognitive deficits overlooks non-neurological dimensions of stroke impact—pain, mood disorders, cognitive decline, and social disability—leading to underdiagnosis of “silent” stroke or post-stroke depression. A 2021 meta-analysis in *The Lancet Neurology** found that Nihss scores underestimated disability in 37% of cases, particularly among elderly and diabetic patients. Moreover, cultural bias in item

interpretation remains a concern: phrases like “right-sided weakness” may be less intuitive in communities where gait abnormalities are normalized or attributed to aging. These limitations have spurred efforts to augment the scale—such as integrating patient-reported outcomes, functional independence measures, and biomarkers—yet the Nih

Questions & Answers About nihss stroke scale test answers

No	Question	Answer
1	What is the NIHSS Stroke Scale used for?	The NIHSS (National Institutes of Health Stroke Scale) is used to objectively quantify the impairment caused by a stroke, helping to assess stroke severity and guide treatment.
2	How is the NIHSS Stroke Scale scored?	The NIHSS is scored based on 11 items assessing consciousness, vision, facial palsy, motor skills, ataxia, sensation, language, speech, and attention, with a total score ranging from 0 to 42.
3	Where can I find official NIHSS Stroke Scale test answers or scoring guidelines?	Official NIHSS scoring guidelines and training materials are available on the NIH Stroke Scale website and through the American Stroke Association.

4	Are there correct 'answers' to the NIHSS Stroke Scale test?	The NIHSS test is an observational assessment of neurological function, not a test with fixed answers; scoring depends on patient responses and clinical signs observed.
5	Can I practice NIHSS Stroke Scale test answers online?	Yes, there are online training modules and practice scenarios provided by authorized organizations to help healthcare professionals learn accurate NIHSS scoring.
6	What is considered a severe score on the NIHSS Stroke Scale?	A NIHSS score above 15 generally indicates a severe stroke, while lower scores suggest mild to moderate impairment.
7	How do you assess language function in the NIHSS Stroke Scale?	Language is assessed by evaluating the patient's ability to name objects, describe a picture, and follow commands, with scoring reflecting the degree of aphasia.
8	Is the NIHSS Stroke Scale used only in hospitals?	While primarily used in hospitals and stroke centers, the NIHSS can also be used by emergency medical personnel and in clinical research.
9	What should I do if I get different NIHSS scores for the same patient?	Variability can occur; ensure proper training, use standardized procedures, and consider repeat assessments to confirm accurate scoring.

10	Can the NIHSS Stroke Scale predict stroke outcomes?	Yes, higher NIHSS scores generally correlate with worse outcomes, but it should be used alongside other clinical information for prognosis.
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NIHSS scoring guide, stroke assessment scale, NIH Stroke Scale instructions, NIHSS test interpretation, stroke severity scale, NIH Stroke Scale training, NIHSS exam answers, neurological deficit scale, stroke evaluation tool, NIHSS scoring criteria

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When to seek support

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