



Health Assessment in Nursing

Janet R. Weber RN EdD, Jane H. Kelley RN PhD

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- Master the “how-to’s” of conducting a nursing assessment through the real world **Continuing Case Study** in every chapter that introduces a client with a health concern, guides you through investigation of symptoms using the COLDSPA mnemonic, and demonstrates a physical assessment, proper documentation techniques, diagnostic reasoning, and appropriate nursing conclusions.
- Access an easy-to-understand tool for data collection with the **Collecting Subjective Data: Nursing Health History table**, which presents Information in two columns: *Questions* that you will ask the client and *Rationales* explaining why the questions are important.
- Master every aspect of the physical examination through the **Collecting Objective Data: Physical Examination table**, which illustrates physical examination procedures in a step-by-step fashion across three columns: *Assessment Procedure* (which explains and illustrates exactly how to perform specific aspects of the examination), *Normal Findings*, and *Abnormal Findings*.
- Identify important distinctions through hundreds of photos exhibited in the **Abnormal Findings displays**.

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