ASSESSMENT FORM

Client: Code Status:

Address: Date:

Phones: Email:

Presenting Problem: Referred by:

Company:

PERSONAL INFORMATION

SSN: Marital Status: DOB:

Age Today: Gender:

Spouse/Partner: Ethnicity:

Employer: Employment Status

Language(s): Religion:

Living Environment:

Service Branch: (spouse/self)

Years of Service: Type of Discharge: VA Pension? Y ☐ N ☐

HEALTH/LONG-TERM CARE INSURANCE

Medicare: Policy Type:

Company Name: Supplemental:

Exp Date: Part D:

Use Order: Other:

Policy Details: Long Term Care:

Primary Caregiver Name:

Address:

Phones:

Email:

Additional Notes:

Responsible Party/Legal Guardian Name:

Address:

Phones:

Email:

Bill To:

Address:

Phones:

Email:

Family Members:

Name:

Address:

Phones:

Email:

PREFERRED PROVIDERS:

Type:		Type:	
Name:		Name:	
Address:		Address:	
Phone/Fax:		Phone/Fax:	

MEDICAL PRACTICE:

HOSPITAL:

PHARMACY/STORE:

MAIL ORDER PHARMACY:

IN-HOME PROVIDERS (agency or private home care):

Name/Company:

Contact Information:

Phone/Fax:

Type of Care Provided:

Comments about care providers:

Additional Notes:

ALLERGIES:

Allergen: | Allergen:

Reaction: | Reaction:

Last Reaction: | Last Reaction:

Allergen: | Allergen:

Reaction: | Reaction:

Last Reaction: | Last Reaction:

MEDICATIONS:

Does client use pill box? ☐ Yes ☐ No

Are refill dates current? ☐ Yes ☐ No

Is client capable of dispensing own meds? ☐ Yes ☐ No

Can client take pills whole? ☐ Yes ☐ No

Notes:

PAST SURGERIES/PROCEDURES: (cataract, hyst, cancer surgery, cystoc, sp, tonsils)

Type of Surgery:

Date Performed:

Result of Surgery:

DIAGNOSES:

Primary Diagnosis:

Secondary Diagnosis:

Chief Complaints:

HOSPITALIZATIONS:

Admit Date: Discharge Date:

Hospital: Admitting MD:

Address:

Reason for admission (list any procedures):

Admit Date: Discharge Date:

Hospital: Admitting MD:

Reason for admission (list any procedures):

MEDICAL ASSESSMENT:

Height: Weight: Date last weighed:

Last flu shot: Last pneumonia shot: Shingles: PPD:

DIAGNOSTIC TESTING (STRESS TEST, MRI, ETC):

Test: Date:

Physician:

Result:

Test: Date:

Physician:

Result:

LAB WORK:

Test: Date:

Physician:

Result:

Test: Date:

Physician:

Result:

ADDITIONAL NOTES:

HEALTH ASSESSMENT:

☐ Home-bound ☐ Bedbound ☐ Wheelchair bound ☐ Unsteady gait ☐ Other:

BARRIERS TO LEARNING:

☐ Cognitive ☐ Emotional ☐ Physical ☐ Other:

PHYSICAL ASSESSMENT BY BODY SYSTEM:

Neurological/Sensory:

☐ Alert Oriented to: ☐ Person ☐ Place ☐ Time ☐ Confused ☐ Memory deficit ☐ Impaired decision-making

☐ Well-groomed ☐ Disheveled ☐ Appropriately Dressed (weather) ☐ Cooperative ☐ Attention span (short, normal)

☐ Depressed ☐ Anxious ☐ Logical thought processes ☐ Emotionally detached ☐ Good eye contact

☐ Wandering ☐ Verbally abusive or inappropriate ☐ Combative/assaultive ☐ Signs of neglect ☐ Good eye contact

☐ Signs of abuse ☐ Signs of drug abuse ☐ Sleep disturbance ☐ Can direct own care ☐ Poor eye contact

☐ Able to implement care ☐ Lethargic but arousable ☐ Unresponsive ☐ Responds to pain PERLA ☐

☐ Hand grasps WNL ☐ Gait WNL ☐ Impaired gross movement ☐ Impaired fine movement ☐ Headaches

☐ Numbness/tingling ☐ Seizures ☐ Tremor ☐ Vertigo ☐ Hallucinations ☐ Past psych history

☐ Macular degeneration ☐ Cataracts ☐ Glaucoma

Vision level: ☐ Normal ☐ Partially Impaired ☐ Severely impaired ☐ Unknown

Notes:

Hearing level: ☐ Normal ☐ Partially Impaired ☐ Severely impaired ☐ Unknown ☐ Hearing Aids

Notes:

Speech level: Normal Partially Impaired Severely impaired Unknown

Notes:

Does client wear: Corrective Lenses Reading Glasses

Mental assessment results:

Depression assessment results:

Notes:

MD involved

Sleep pattern:

Number of hours of sleep per night: Time to bed: Time up:

Nap?: # hours: Do you snore?:

Quality of sleep:

Number of times out of bed to bathroom at night: Able to go back to sleep immediately?

Do you dream? Do you sleep walk?:

Do you take medicine to sleep? Yes No If so, what medicine?:

Pain Assessment: (arthritis, back, hip, frequent HA, soreness, stiffness)

Pain medication details:

Cardiovascular:

☐ Palpitations ☐ Chest pain ☐ Pedal pulses WNL ☐ Pacemaker ☐ Edema ☐ Color WNL

☐ Color pale ☐ Color gray/dusky ☐ Color mottled ☐ Nail beds pink

Apical pulse: ☐ regular OR ☐ irregular

Radial pulse: ☐ regular OR ☐ irregular

Blood pressure: _____ (left arm)

Blood pressure: _____ (right arm)

Blood pressure: _____ (lying)

Blood pressure: _____ (standing)

Notes:

MD involved:

Respiratory:

☐ SOB at rest ☐ SOB with exertion ☐ Orthopnea ☐ Chest expansion equal ☐ Barrel chest

☐ Nasal flaring ☐ Hemoptysis ☐ Night sweats ☐ HX Asthma ☐ SAO2%

☐ Dry cough ☐ Productive cough ☐ Years smoker: _____ PPD: _____ Quit: _____

Breath sounds: Right: _____ Left: _____

Respiratory rate and characteristics:

Notes:

Musculoskeletal:

☐ ROM WNL ☐ ROM limited ☐ Contractures ☐ Atrophy ☐ Gait WNL ☐ Weakness ☐ Arthritis ☐ Prosthesis

☐ Deformity ☐ Swollen joints ☐ Fractures ☐ Cast ☐ Spasticity ☐ Amputation ☐ Assistive devices

(ADL/iADL ASSESSMENT RESULTS GO HERE)

(FALL ASSESSMENT RESULTS GO HERE)

History of falls within the past three months: ☐ Yes ☐ No

Does client have Emergency Pendant? ☐ Yes ☐ No If so, Brand: _____

Notes: _____

Gastrointestinal:

☐ Teeth WNL ☐ Partial dentures top/bottom ☐ Full dentures ☐ Sores in mouth/thrush ☐ Difficulty chewing

☐ Difficulty swallowing ☐ Nausea ☐ Vomiting ☐ Heartburn ☐ Stomach pain ☐ Abdomen WNL

☐ Abdomen distended ☐ Abdomen tender ☐ Bowel sounds WNL ☐ Colostomy ☐ Flatulence

☐ Hemorrhoids ☐ Rectal bleeding ☐ Constipation ☐ Diarrhea ☐ Change in bowel habits ☐ Tube fed

Recent weight gain ☐ Recent weight loss ☐

Normal BM pattern: _____ Date of last BM: _____ ☐ Depends

Continence status: ☐ continent ☐ incontinent

Current diet: ☐ Regular ☐ Low Salt ☐ Low cholesterol ☐ Diabetic ☐ Restricted calorie ☐

Other: _____

Number meals eaten per day: _____

☐ Reg. consistency ☐ Mech. Soft ☐ Thickened liquids ☐ Thin liquids ☐ Puree

Number of servings per day of: Fruit ☐ Vegetable ☐ Dairy ☐ Protein ☐

Non-alcoholic fluids _____ oz./day Alcohol consumption _____ oz./day

Notes: _____

How does client view nutritional habits: ☐ poor ☐ adequate ☐ good ☐ unknown

other: _____

Appetite: ☐ poor ☐ adequate ☐ good ☐ excellent

Does client eat alone: ☐ Yes ☐ No

Does client get Meals on Wheels: ☐ Yes ☐ No

Is client interested in Meals on Wheels: ☐ Yes ☐ No

How is food Obtained & Prepared: _____

How often does client visit his/her dentist? Last visit

Notes:

Genitourinary:

☐ Voids WNL ☐ Catheter ☐ Burning Frequency ☐ Nocturia ☐ Dysuria ☐ Oliguria

☐ Hematuria ☐ Enlarged Prostate ☐ Hesitancy ☐ Retention

Continence status: ☐ continent ☐ incontinent ☐ manages independently ☐ requires help in bathroom

☐ Depends ☐ Incontinence pads ☐ Catheter ☐ Urinal

Number of times client voids per day: Do you leak urine w/coughing/sneezing?

Notes:

MD Involved:

Integumentary:

☐ Skin intact ☐ Turgor WNL ☐ Moist/dry WNL ☐ Rashes ☐ Lesions ☐ Pruritis ☐ Petechiae

☐ Jaundice ☐ Bruising ☐ Diaphoresis ☐ Itchy Skin ☐ Dry/scaling ☐ Wound ☐ Incision

☐ Birthmarks ☐ Scars ☐ Well-hydrated

Notes:

MD Involved

Endocrine:

Problems w/thyroid: ☐ YES ☐ NO If yes, describe issues:

Diabetes: ☐ No ☐ Non-insulin dependent ☐ Insulin dependent ☐ Peripheral neuropathy

☐ Vision Difficulties/blurry vision ☐ Thirsty ☐ Excessive fatigue ☐ Polyuria ☐ Slow-healing cuts/sores

☐ Increased appetite

Frequency of finger sticks:

Last HbA1C Date:

Foot care ☐ Podiatrist to cut toe nails ☐ Wear shoes ☐ Check feet daily

Notes:

MD involved

Rehabilitation potential:

☐ Acute condition ☐ Chronic condition ☐ Full recovery expected

☐ Partial recovery expected ☐ No recovery expected

Notes:

Assistive Devices:

Device used: Device used:

Is client using device properly: Is client using device properly:

Provider of device: Provider of device:

Phone: Phone:

Device used: Device used:

Is client using device properly: Is client using device properly:

Provider of device: Provider of device:

Phone: Phone:

Legal Assessment:

Attorney(s):

Name:

Specialty:

Address: Phone/Fax:

Name:

Specialty:

Address: Phone/Fax:

Documents:

Document type:

Date:

Attorney:

Location of documents:

WILL:

ADVANCE DIRECTIVE FOR HEALTHCARE:

POWER OF ATTORNEY:

GUARDIANSHIP/CONSERVATORSHIP:

ADDITIONAL NOTES:

END OF LIFE PLANNING:

Funeral Home:

Cemetery/Plot#:

Funeral Arrangements:

People to Notify:

Funeral Pre-Paid? ☐ Yes ☐ No

If yes, where is paperwork?

Additional Notes: