ASSESSMENT: NURSING

Client Name: _____ Client Phone: _____

Client Address: _____

Doctor's Name: _____Doctor's Phone: _____

Contact Person: _____ Contact's Phone: _____

General Topics	Subject Matter	Action(S) Indicated
	MEDICAL INFORMATION	
Medical Conditions	_____ _____ _____ _____ _____ _____	
Medical Background	Major Surgeries Illnesses _____ _____ _____ _____ _____ _____	
Hospitalizations	Recent (Last 2 Years) Previous _____ _____ _____ _____ _____ _____	
Height & Weight	Height: _____ Weight: _____ Weight Status: ____ Increase ____ Static ____ Decrease Reason for Any Weight Change:_____	
Vital Signs	_____ Blood Pressure _____ Pulse _____ Respirations _____ Temperature	

General Topics	Subject Matter	Action(S) Indicated
Medications	_____ _____ _____ _____ _____ _____ _____ _____	
Medication Allergies	_____ _____ _____ _____ _____ _____	
Current Treatments	_____ _____ _____ _____ _____ _____	
Current Therapy	_____ _____ _____ _____	
Dental Care	Does client have dental problems? ____ Yes ___No Is Client Under Care of Dentist? ____ Yes ___No Dental State: ___No Dentures ____ Dentures Damaged ___Full Upper ____ No Dentures ___Full Lower ____ Not Wearing Dentures ___Partial Denture ____ No Teeth Can Client Chew Food Effectively? ____Yes ____No Dentist's Name:_____ Dentist's Phone Number :_____	
Vision	___ Unimpaired ___ Blind - Safe in Familiar Locale ___ Adequate for Personal Safety ___ Blind - Requires Assistance ___ Distinguishes Only Light or Dark Wears Glasses: ___Yes ____No	
Hearing	___ Unimpaired ___ Mild Impairment ___ Moderate Impairment but Not a Threat to Safety ___ Impaired –Safety threat exists. ___ Totally Deaf Uses Hearing Aid(s): ____ Yes ____ Right Ear ____Left Ear _____ No	

General Topics	Subject Matter	Action(S) Indicated
Mental Health	**Attitude** ___Cooperative ___Indifferent ___Resistive ___Demanding ___Suspicious ___Hostile **Appearance** ___ Well Groomed ____ Adequate ____ Disheveled ____ Inappropriately Dressed ____ Not Dressed **Self-Direction** ___ Independent ___ Needs Motivation ___ Dependent ___ Needs Direction **Behavior** ____ Normal ____ Wandering ____Sun downing ____Restless ____Hostile ____ Withdrawn ____ Self-Destructive ____ Safety Hazard ____ Aggressive _____Verbal ____ Physical **Influence** ____ Appropriate ____ Inappropriate ____ Anxious ____ Blunted ____ Euphoric ____ Depressed ____ Angry _____ Mood Swings **Thought Content** ____ Normal ____ Delusions ____ Obsessions ____ Phobias ____ Persecutory ____ Guilt ____ Can't Assess **Perceptions** ____ Normal ____ Hallucinations ____ Auditory ____ Visual ____ Other **Cognition** ____ Normal ____ Impairment ____ Mild ____ Moderate ____ Severe **Insight** ____ Good ____ Partial ____ None **Judgment** ____Good ____ Adequate ____ Poor	
LIVING HABITS		
Smoking Habits	**Client Smokes** Yes: _____ No: _____ **Degree of Problem** _____ No Problem _____ Some Problem _____ Major Problem	
Alcohol Consumption	**Client Drinks** Yes: _____ No: _____ **Degree of Problem** _____ No Problem _____ Some Problem _____ Major Problem	
Current Diet	Regular _____ Diabetic _____ Low Fat _____ Takes Supplement (E.g. Ensure) _____ Low Salt _____ Vegetarian _____ Other _____	
Allergies Food & Other	_____ _____ _____ _____ _____ _____	

General Topics	Subject Matter	Action(S) Indicated
Eating Habits	_____ Good _____ Fair _____ Poor Comments: _____ _____	
COMMUNCATION		
Language Spoken	___English ____ Italian ___French ____ Spanish ___Chinese ____ Russian ___Japanese ____ East Indian ____ Other _____	
Speech	___ Unimpaired. ___ Simple Phrases - Understandable ___ Simple Phrases - Partially Understandable ___ Isolated Words – Understandable ____Speech Not Understandable or Does Not Make Sense ____ Does Not Speak If Client Cannot Speak, Indicate Method of Communicating_____ _____ Method is: ___Effective ___Partially Effective ___Moderately Effective ___Not Effective	
Understanding	___Unimpaired ___Understands Simple Phrases Only ___Understands Key Words Only ___Understanding Unknown ___Not Responsive	
ACTIVITIES OF DAILY LIVING		
Mobility Aids	___Uses Cane ___Uses Walker ___Uses Crutches ___Uses Wheelchair: ___Manual ___Electric ___Uses Grab Bars ___ Other Prosthesis or Aid:_____	
Ambulation	___Independent in Normal Environments ___Independent Only in Specific Environment ___Requires Supervision ___Requires Occasional or Minor Assistance ___Requires significant or Continued Assistance	

General Topics	Subject Matter	Action(S) Indicated
Transferring	____Independent ____ Needs Supervision transferring to: ____ Bed ____Chair ____Toilet ____ Needs Intermittent Assistance transferring to: ____ Bed ____Chair ____Toilet ____ Needs Continued Assistance transferring to: ____ Bed ____Chair ____Toilet ____ Completely Dependent for All Movements	
Bathing	____Independent in Bathtub or Shower ____ Independent with Mechanical Aids (E.g. bath seat) ____ Requires Minor Assistance or Supervision: ____Getting in and Out of Tub/Shower ____ Turning Taps on and Off ____ Washing Back ____ Requires Continued Assistance ____ Resists Assistance ____ Other _____	
Dressing	____ Independent ____ Supervision or Needs some help: ____ Selecting Appropriate Clothing ____ Coordinating Colours ____ Periodic or Daily Help Needed: ____ Putting on Clothing ____ Doing up Buttons, Laces, Zippers ____ Pulling on Trousers, Socks, Shoes ____ Determining Condition or Cleanliness of Clothing	
Grooming & Hygiene	____Independent ____Requires Reminder, Motivation&/or Direction ____Requires Assistance with Some Things ____Putting Toothpaste of Toothbrush ____ Using Electric Razor ____ Requires Total Assistance ____ Resists Assistance	
Eating	____ Independent ____ Independent with Special Provision for Disability ____ Requires Intermittent Help With: ____ Cutting Up/Pureeing Food ____ Must Be Fed ____ Resists Feeding	
Bladder Control	____Totally Continent ____ Needs Routine Toileting or Reminder ____ Incontinent Due to Identifiable Factors ____ Incontinent Once Per Day ____ Incontinent More than Once per Day	
Bowel Control	____ Has Total Control ____ Needs Routine Toileting or Reminder ____ No Bowel Control Due to Identifiable Factors ____ Loses Bowel Control Once Per Day ____ Loses Bowel Control More than Once per Day	
Toileting	____ Requires Raised Toilet Seat or Commode ____ Has Difficulty with Buttons, Zippers ____ Needs Help with Aids (E.g. Catheter, Condom Drainage, etc.)	

General Topics	Subject Matter	Action(S) Indicated
	____ Other: _____	
Exercising	____ Exercises Regularly: ____ Daily ____ Alternate Days ____Twice a Week ____ Weekly ____ Other _____ ____ Time and/or Distance _____ ____ Recent Changes to Exercise Regime_____ ____ Exercise Alone ____ Exercises with Attendant ____ Other _____ _____	
INSTRUMENTAL ACTIVITIES OF DAILY LIVING		
Preparing Food	____ Independent ____ Adequate if Ingredients Supplied ____ Can Make or Buy Meals but Diet is Inadequate ____ Physically or Mentally Unable to Prepare Food ____ No Opportunity to Prepare Food or Chooses Not to Prepare Food	
Housekeeping	____ Independent ____ Generally Independent but Needs Help with Heavier Tasks ____ Can Perform Only Light Tasks Adequately ____ Performs Light Tasks but Not Adequately ____ Needs Regular Help and/or Supervision ____ No Opportunity to Do Housework or Chooses Not to Do Housework	
Shopping	____ Independent ____ Independent but For Small Items Only ____ Can Shop if Accompanied ____ Physically or Mentally Unable to Shop ____ No Opportunity to Shop or Chooses Not to Shop	
Transportation	____ Uses Private Vehicle ____ Uses Taxi or Bus ____ Independent ____ Must be Accompanied ____ Must be Driven ____ Physically or Mentally Unable to Travel ____ Needs Ambulance for Transporting	
Telephone	____ Independent ____ Can Dial Well Known Numbers ____ Answers Telephone Only ____ Physically or Mentally Unable to Use Telephone ____ No Opportunity to Use Telephone or Chooses Not to Use Telephone	
Medication/ Treatments	____ Completely Responsible for Self ____ Requires Reminder or Assistance ____ Responsible if Medications Prepared in Blistopax ____ Physically or Mentally Unable to Take Medications and Conduct Treatments	

General Topics	Subject Matter	Action(S) Indicated
	____ Resists Taking Medication or Conducting Treatments	
ATTENDANT PROFILE		
Attendant	____ Independent ____ Needs an Attendant ____ Frequency of Attendant Assistance ____ Intermittent ____ Constantly ____ During Day ____ During Night ____ Attendant Needs Met by: ____ Spouse ____ Friend ____ Family ____Other _____	
SOCIAL PROFILE		
Housing	____ House ____ Self Owned ____ Apartment ____ Rental ____ Condominium ____ Mobile Home ____ Room ____Urban ____ Facility ____Rural ____ Other_____	
Living Companions	____ Lives Alone ____ Lives with Spouse or Spousal Equivalent ____ Lives with Adult Children ____ Lives with Child(ren) ____Lives with Other Adult Male ____ Lives with Other Adult Female ____ Principal Helper: _____	
Religion & Culture	____ Ethnicity: _____ ____ Religion: _____	
FINANCIAL PROFILE		
Financial Benefits	Financial Benefits: ____ Old Age Security Pension ____ Guaranteed Income Supplement ____ Gains for Senior ____ War Veterans Allowance or Disability Pension ____ Company Pension ____ Other: _____ ____ Other: _____	
Financial Management	____ Self ____ Spouse ____ Family ____ Friend ____ Public Trustee ____ Power of Attorney ____ Other: _____	
Financial	____ Appropriate	

General Topics	Subject Matter	Action(S) Indicated
Arrangements	____ Not Appropriate	
ADDITIONAL INFORMATION		

Date: _____

_____
Assessor's Name & Position

_____
Assessor's Signature

_____
Client/Client's Representative's Signature