

**ASSESSMENT: NURSING**

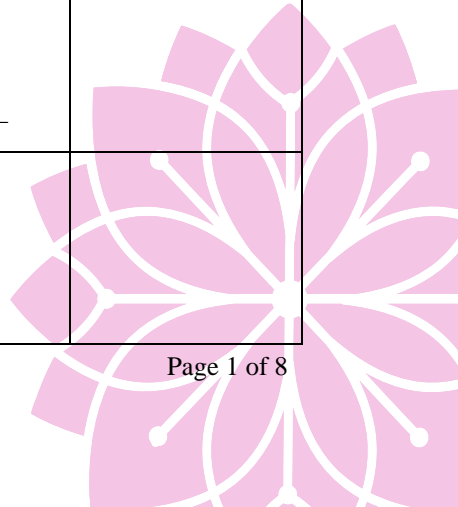
Client Name: \_\_\_\_\_ Client Phone: \_\_\_\_\_

Client Address: \_\_\_\_\_

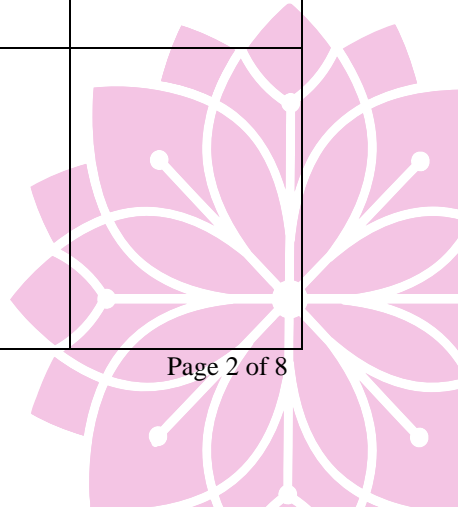
Doctor's Name: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_

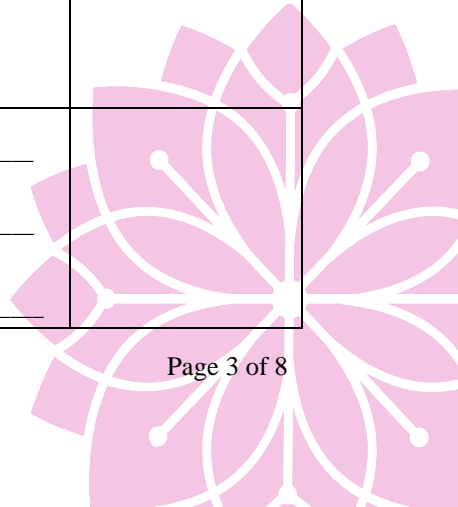
General Topics	Subject Matter	Action(S) Indicated								
<b>MEDICAL INFORMATION</b>										
Medical Conditions	_____ _____ _____									
Medical Background	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><u>Major Surgeries</u></td> <td style="width: 50%;"><u>Illnesses</u></td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	<u>Major Surgeries</u>	<u>Illnesses</u>	_____	_____	_____	_____	_____	_____	
<u>Major Surgeries</u>	<u>Illnesses</u>									
_____	_____									
_____	_____									
_____	_____									
Hospitalizations	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><u>Recent (Last 2 Years)</u></td> <td style="width: 50%;"><u>Previous</u></td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	<u>Recent (Last 2 Years)</u>	<u>Previous</u>	_____	_____	_____	_____	_____	_____	
<u>Recent (Last 2 Years)</u>	<u>Previous</u>									
_____	_____									
_____	_____									
_____	_____									
Height & Weight	Height: _____ Weight: _____ Weight Status: ___ Increase ___ Static ___ Decrease Reason for Any Weight Change: _____									
Vital Signs	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">_____ Blood Pressure</td> <td style="width: 50%;">_____ Pulse</td> </tr> <tr> <td>_____ Respirations</td> <td>_____ Temperature</td> </tr> </table>	_____ Blood Pressure	_____ Pulse	_____ Respirations	_____ Temperature					
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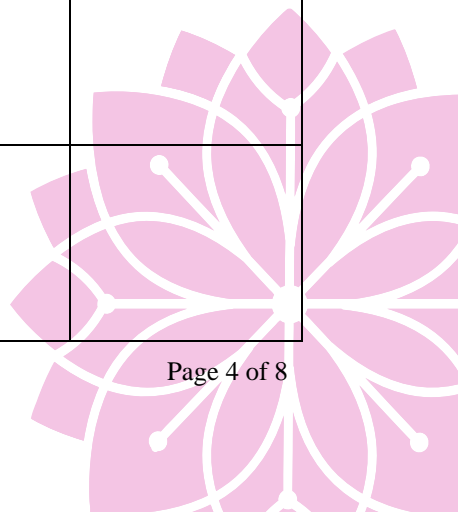
General Topics	Subject Matter	Action(S) Indicated
Medications	_____ _____ _____ _____	
Medication Allergies	_____ _____ _____	
Current Treatments	_____ _____ _____	
Current Therapy	_____ _____	
Dental Care	Does client have dental problems? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Client Under Care of Dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No Dental State: <input type="checkbox"/> No Dentures <input type="checkbox"/> Dentures Damaged <input type="checkbox"/> Full Upper <input type="checkbox"/> No Dentures <input type="checkbox"/> Full Lower <input type="checkbox"/> Not Wearing Dentures <input type="checkbox"/> Partial Denture <input type="checkbox"/> No Teeth  Can Client Chew Food Effectively? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist's Name: _____ Dentist's Phone Number : _____	
Vision	<input type="checkbox"/> Unimpaired <input type="checkbox"/> Blind - Safe in Familiar Locale <input type="checkbox"/> Adequate for Personal Safety <input type="checkbox"/> Blind - Requires Assistance <input type="checkbox"/> Distinguishes Only Light or Dark  Wears Glasses: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing	<input type="checkbox"/> Unimpaired <input type="checkbox"/> Mild Impairment <input type="checkbox"/> Moderate Impairment but Not a Threat to Safety <input type="checkbox"/> Impaired –Safety threat exists. <input type="checkbox"/> Totally Deaf  Uses Hearing Aid(s): <input type="checkbox"/> Yes <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> No	



General Topics	Subject Matter		Action(S) Indicated		
Mental Health	<u>Attitude</u> <input type="checkbox"/> Cooperative <input type="checkbox"/> Indifferent <input type="checkbox"/> Resistive <input type="checkbox"/> Demanding <input type="checkbox"/> Suspicious <input type="checkbox"/> Hostile	<u>Appearance</u> <input type="checkbox"/> Well Groomed <input type="checkbox"/> Adequate <input type="checkbox"/> Disheveled <input type="checkbox"/> Inappropriately Dressed <input type="checkbox"/> Not Dressed	<u>Self-Direction</u> <input type="checkbox"/> Independent <input type="checkbox"/> Needs Motivation <input type="checkbox"/> Dependent <input type="checkbox"/> Needs Direction		
	<u>Behavior</u> <input type="checkbox"/> Normal <input type="checkbox"/> Wandering <input type="checkbox"/> Sun downing <input type="checkbox"/> Restless <input type="checkbox"/> Hostile <input type="checkbox"/> Withdrawn <input type="checkbox"/> Self-Destructive <input type="checkbox"/> Safety Hazard <input type="checkbox"/> Aggressive <input type="checkbox"/> Verbal <input type="checkbox"/> Physical	<u>Influence</u> <input type="checkbox"/> Appropriate <input type="checkbox"/> Inappropriate <input type="checkbox"/> Anxious <input type="checkbox"/> Blunted <input type="checkbox"/> Euphoric <input type="checkbox"/> Depressed <input type="checkbox"/> Angry <input type="checkbox"/> Mood Swings	<u>Thought Content</u> <input type="checkbox"/> Normal <input type="checkbox"/> Delusions <input type="checkbox"/> Obsessions <input type="checkbox"/> Phobias <input type="checkbox"/> Persecutory <input type="checkbox"/> Guilt <input type="checkbox"/> Can't Assess		
	<u>Perceptions</u> <input type="checkbox"/> Normal <input type="checkbox"/> Hallucinations <input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Other	<u>Cognition</u> <input type="checkbox"/> Normal <input type="checkbox"/> Impairment <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<u>Insight</u> <input type="checkbox"/> Good <input type="checkbox"/> Partial <input type="checkbox"/> None		<u>Judgment</u> <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor
	<b>LIVING HABITS</b>				
Smoking Habits	<u>Client Smokes</u> Yes: _____ No: _____		<u>Degree of Problem</u> <input type="checkbox"/> No Problem <input type="checkbox"/> Some Problem <input type="checkbox"/> Major Problem		
Alcohol Consumption	<u>Client Drinks</u> Yes: _____ No: _____		<u>Degree of Problem</u> <input type="checkbox"/> No Problem <input type="checkbox"/> Some Problem <input type="checkbox"/> 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	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Comments: _____ _____	
<b>COMMUNICATION</b>		
Language Spoken	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Other _____ <input type="checkbox"/> Italian <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> East Indian	
Speech	<input type="checkbox"/> Unimpaired. <input type="checkbox"/> Simple Phrases - Understandable <input type="checkbox"/> Simple Phrases - Partially Understandable <input type="checkbox"/> Isolated Words – Understandable <input type="checkbox"/> Speech Not Understandable or Does Not Make Sense <input type="checkbox"/> Does Not Speak If Client Cannot Speak, Indicate Method of Communicating _____ _____ Method is: <input type="checkbox"/> Effective <input type="checkbox"/> Partially Effective <input type="checkbox"/> Moderately Effective <input type="checkbox"/> Not Effective	
Understanding	<input type="checkbox"/> Unimpaired <input type="checkbox"/> Understands Simple Phrases Only <input type="checkbox"/> Understands Key Words Only <input type="checkbox"/> Understanding Unknown <input type="checkbox"/> Not Responsive	
<b>ACTIVITIES OF DAILY LIVING</b>		
Mobility Aids	<input type="checkbox"/> Uses Cane <input type="checkbox"/> Uses Walker <input type="checkbox"/> Uses Crutches <input type="checkbox"/> Uses Wheelchair: <input type="checkbox"/> Manual <input type="checkbox"/> Electric <input type="checkbox"/> Uses Grab Bars <input type="checkbox"/> Other Prosthesis or Aid: _____	
Ambulation	<input type="checkbox"/> Independent in Normal Environments <input type="checkbox"/> Independent Only in Specific Environment <input type="checkbox"/> Requires Supervision <input type="checkbox"/> Requires Occasional or Minor Assistance <input type="checkbox"/> Requires significant or Continued Assistance	



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

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



General Topics	Subject Matter	Action(S) Indicated
Arrangements	____ Not Appropriate	
<b>ADDITIONAL INFORMATION</b>		

Date: \_\_\_\_\_

\_\_\_\_\_  
Assessor's Name & Position

\_\_\_\_\_  
Assessor's Signature

\_\_\_\_\_  
Client/Client's Representative's Signature

