NURSE Jackie HOMECARE
Non-Medical Home Care Agency

ASSESSMENT: PERSONAL CARE

Client Name: ____ Client Phone: _______________

Client Address: ____

Doctor's Name: ______________________________________ Doctor's Phone: ______________

Contact Person: _____________________________________ Contact's Phone: ______________

PERSONAL CARE						
ACTIVITY		Level of Assistance Needed				ACTIONS
		Supervise/ Remind	Minor Assistance	Substantial Assistance	Total Assistance	
BATHING ___ **No Assistance Needed**	Bath tub and/or Shower					
	In & Out					
	Taps On & Off					
	Wash Back					
	Wash Feet					
	Bed Bath					
	Partial Bed Bath					
	Complete Bed Bath					
DRESSSING & UNDRESSING ___ **No Assistance Needed**	Select Appropriate Clothing					
	Color Coordination					
	Condition					
	Cleanliness					
	Put On/Take Off. Clothing					
	Do Up/Undo Buttons, Laces, & Zippers					
	Pull on/Take Off Trousers/Socks/Shoes					

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PERSONAL CARE						
ACTIVITY		**Level of Assistance Needed**				**ACTIONS**
		Supervise/ Remind	**Minor Assistance**	**Substantial Assistance**	**Total Assistance**	
	Put On/Take Off Prosthesis					
GROOMING & HYGIENE __ **No Assistance Needed**	Shampoo Hair					
	Comb/Style Hair					
	Shave (With Electric Razor)					
	Brush Teeth					
	Floss Teeth					
	Clean Dentures					
	Put Toothpaste on Brush					
	Routine Nail Care (not for clients with diabetes or circulation problems)					
EATING ___ **No Assistance Needed**	Cut Up Food					
	Handle Utensils					
	Puree Food					
	Eating					
BLADDER CONTROL __ **No Assistance Needed**	Routine Toileting					
	Handle Clothing/Zipper					
	Incontinency Care					
	Catheter Drainage					
	Condom Drainage					
BOWEL CONTROL ___ **No Assistance Needed**	Routine Toileting					
	After Toileting Cleanup					
	Handle Clothing/Zipper					
	Incontinency Care					
	Colostomy Care					

PERSONAL CARE						
ACTIVITY		**Level of Assistance Needed**				**ACTIONS**
		Supervise/ Remind	**Minor Assistance**	**Substantial Assistance**	**Total Assistance**	
	Enemas					
	Rectal Suppositories					
TRANSFERRING, & LIFTING **__ No Assistance Needed**	On & Off Toilet/Commode					
	To & From Chair & Bed					
	In and out of vehicle					
TURNING **__ No Assistance Needed**	Every 2 hours					
	Other:					
AMBULATION **___No Assistance Needed**	Uses Mobility Devices					
	Requires Attendant Support					
EXERCISING **__ No Assistance Needed**	Self-Performed					
	Conducted by HCA					
	Conducted at Physio					
BODY FUNCTIONING **___ No Assistance Needed**	Determine weight & record					
	Monitor urine Input & Output					
	Collect Urine, Stool, & Sputum Samples					
	Monitor Blood Pressures, Temperature, Pulse & Respirations					
	Monitor Oxygen Usage					
MEDICATIONS ___ No Assistance Needed	Remind/prompt to take					
	Open blister pack/other packaging					

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PERSONAL CARE						
ACTIVITY		Level of Assistance Needed				ACTIONS
		Supervise/ Remind	Minor Assistance	Substantial Assistance	Total Assistance	
OTHER						
OTHER						

Date: ______________________

____
Assessor's Name & Position

____
Assessor's Signature

____
Client/Client's Representative's Signature