



INITIAL ASSESSMENT

START OF CARE: ____/____/____

DATE OF ASSESSMENT: ____/____/____

TIME: ____AM/PM

EMERGENCY PRIORITY CODE: _____

CLIENT NAME: _____ **DOB:** ____/____/____ **Age** ____

ADVANCED DIRECTIVE? **NO** **YES** **LOCATION:** _____

ALLERGIES: NKA OTHER: _____

GENDER: _____ **LANGUAGE SPOKEN:** _____

CLIENT LIVES: ALONE WITH SPOUSE WITH FAMILY OTHER: _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

PHONE #: ____-____-____, **2ND PHONE #:** ____-____-____

NUTRITIONAL STATUS: REGULAR DIET LOW SALT DIABETIC

OTHER/DESCRIBE: _____

MEDICAL/NURSING DIAGNOSIS: _____

PAST MEDICAL HISTORY:

VITAL SIGNS:

TEMP: ____ **PULSE:** ____ **RESPIR:** ____ **B/P** ____/____

Pain: Yes No

PAIN SCALE USED: NUMERIC FLACC FACES (PEDS)

Rated as: _____ **out of:** _____ **Site:** _____

Character: Ache Sharp Dull Pressure **Frequency:** _____

Precipitating Factors: Ambulation Transfer Weight Bearing Activity **Other:** _____

If NO pain noted, last time pain was present (if at all): _____

Current pain medications: _____

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Is pain medication effective? ___Yes ___No Intensity after pain medication: _____

Other relief measures: ___Rest ___Music ___Reading ___Prayer/Meditation ___Deep Breathing

Other: _____

FUNCTIONAL STATUS:

MOBILITY: ___ Bed Rest with BRP ___ Bed Rest ONLY ___ Ambulates Independently

___ Walks with Cane/Walker ___ Needs Wheelchair

AUDITORY: ___ NO PROBLEMS ___ HOH Wears Hearing Aids: ___ RIGHT ___ LEFT

VISION: ___ Wears Glasses ___ Legally Blind ___ NO VISION

SPEECH: ___ NO DEFICITS ___ Difficulty Speaking ___ DOES NOT SPEAK

NEEDS ASSISTANCE WITH:

___ Dressing ___ Bathing/Shampoo ___ Oral Care ___ Grooming

___ Feeding ___ Bowel/Bladder ___ Medication ___ Transferring from Bed to Chair

****REVIEW OF SYSTEMS****

HEAD: ___ NO PROBLEMS ___ Headaches ___ Migraines ___ Dizziness ___ Bump(s)

___ Bruising ___ Laceration ___ OTHER: _____

EYES: ___ NO PROBLEMS ___ Red ___ Dry ___ Irritated ___ Discharge

___ Cataracts ___ OTHER:

NOSE: ___ NO PROBLEMS ___ Bleeding ___ Drainage

___ Nasal Flare ___ Sinus Infection ___ Mouth Breather

INITIAL ASSESSMENT

START OF CARE: ____/____/____

MOUTH/THROAT: ____ NO PROBLEMS ____ Decrease in Taste ____ Dry Mouth

____ Sore Throat ____ Hoarseness ____ Dysphagia

DENTURES: ____ Upper ____ Lower ____ Both

OTHER: _____

CARDIAC: ____ NO PROBLEMS ____ NSR ____ Murmurs Noted ____ Pacemaker ____ JVD

____ Palpitations ____ Abnormal Rhythm ____ Hypertension ____ Hypotensive

____ **C/O CHEST PAIN IF YES:** Frequency _____ Type: _____ Location: _____

PULMONARY: ____ NO PROBLEM ____ Sob ____ DOE ____ Wheeze ____ Cough ____ Productive

NON- PRODUCTIVE SECRETIONS ____ NO ____ YES DESCRIBE _____

OXYGEN: ____ NO ____ YES ____ CONTINUOUS ____ INTERMITTENT **IF YES** LPM _____

____ VENTILATOR DEPENDENT **IF YES,** TYPE OF VENTILATOR _____

Trach: ____ No ____ Yes **IF YES,** Size: _____ Smoker: ____ No ____ Yes

Other: _____

BREAST: ____ NO PROBLEMS ____ Pain/Tenderness ____ Bruising ____ Dimpling

____ Lump(s) ____ Mastectomy OTHER: _____

CIRCULATORY: ____ NO PROBLEMS ____ Varicose Veins ____ Phlebitis ____ Cold Extremities

____ Poor Capillary Refill ____ Nail Clubbing ____ Cyanosis

____ Venous Stasis Ulcer **IF YES,** Location: _____

OTHER: _____

GASTRO/INTESTINAL: ____ NO PROBLEMS ____ Diarrhea ____ Constipation ____ Nausea ____ Vomiting

____ Excessive Flatulence ____ Pain/Tenderness ____ Hernia ____ Stomach Ache

INITIAL ASSESSMENT

START OF CARE: ____/____/____

___ Blood in Stool ___ Recent Change in Bowel Habits

OTHER: _____

NUTRITION: ___ Regular Diet ___ Soft Foods ___ Low Sodium ___ Diabetic Diet OTHER: _____

___ Poor Appetite ___ Good Appetite ___ G-Tube Formula: ____ RATE: ____ VOL: ____

GENITOURINARY: ___ NO PROBLEMS ___ Urgency ___ Nocturia ___ Burning ___ Frequency

___ Hematuria ___ Oliguria ___ Dysuria ___ Retention ___ Pain ___ Incontinent

___ Ilioconduit ___ Catheter: Size _____

REPRODUCTIVE:

FEMALE: ___ NO PROBLEMS ___ Vaginal Bleeding ___ Menopausal ___ Hysterectomy

___ OTHER: _____

MALE: ___ NO PROBLEMS ___ Pain/Tenderness ___ Prostate Enlargement ___ Swelling

___ Testicular Enlargement ___ OTHER: _____

ENDOCRINE: ___ NO PROBLEMS ___ Diabetic ___ Hypoglycemia ___ Hyperthyroidism

___ Hypothyroidism ___ OTHER: _____

MUSCULAR/SKELETAL: ___ NO PROBLEMS ___ Weakness ___ Pain ___ Pain ___ Stiffness

___ Contractures ___ Shaking ___ OTHER: _____

INTEGUMENTARY: ___ NO PROBLEMS ___ Rash ___ Bruising ___ Skin Tear(s)

___ Decubitus Ulcer(s) ___ Prurities ___ Incision ___ Eczema

DESCRIBE SIZE, STAGE, LOCATION, OTHER _____

NEUROLOGICAL: ___ NO PROBLEMS ORIENTED TO: ___ Person ___ Place ___ Time ___ PERLA

___ Hand Grasps WNL ___ Seizures ___ Confused ___ Able to Follow Directions

INITIAL ASSESSMENT

START OF CARE: ____/____/____

___ Numbness ___ Tingling ___ Vertigo ___ Tremors ___ Slurred Speech

___ Agitated ___ Sleepiness ___ Stuporous ___ Lethargic

___ Memory Loss: ___ Short Term ___ Long Term ___ OTHER: _____

PSYCH/SOCIAL: ___ NO PROBLEMS ___ Cooperative ___ Uncooperative ___ Anxious ___ Depressed

___ Aggressive ___ Memory Defect ___ Impaired Decision Making ___ Hostile

___ History of Alcohol Abuse ___ History of Drug Use

CLIENT UNDERSTANDS THE PLAN OF CARE ___ YES ___ NO COMMENTS: _____

Sleep Patterns: ___ NO PROBLEMS ___ Insomnia ___ Disrupted Sleep

****HOME SAFETY REVIEW/FALL ASSESSMENT****

Is smoking allowed in the home?	Yes	No
Are there working smoke detectors/alarms in the home?	Yes	No
Is there an accessible escape in case of fire?	Yes	No
Are there overcrowded electrical outlets?	Yes	No
Is a portable heater used in the home?	Yes	No
Is the stove/oven electric	Yes	No
Is the stove/oven gas	Yes	No
Are there any flammable items near the range top?	Yes	No
Are there any loose rugs, linoleum tiles or mats that could cause tripping?	Yes	No
Are there loose wires/cords/materials around living areas that could cause trip?	Yes	No
Are living areas free of clutter?	Yes	No
Is furniture steady and secured?	Yes	No
Is the walker/cane/assistive device within arm's reach of client?	Yes	No
Does the client experience episodes of dizziness/vertigo or unsteadiness?	Yes	No
Are there proper assistive devices for the client that would help prevent a fall?	Yes	No
Are there animals in the home?	Yes	No
If so, are they adequately cared for?	Yes	No

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By whom? _____

Are the animals well behaved and non-threatening? Yes No
 Is the client taking anti-hypertensive medication? Yes No
 Is the client taking antipsychotic medication? Yes No
 Does the client take a sleep aid at night? Yes No

Is this client at risk of falling based on the above assessment? Yes No

Is family aware of client's fall risk? Yes No

What will be done to prevent a fall for this client??

Equipment in Home:

___ Wheelchair ___ Walker ___ Cane ___ Hospital Bed ___ Hoyer Lift ___ Commode
 ___ Shower Chair ___ Oxygen Concentrator ___ Oxygen Tank ___ Nebulizer ___ CPAP

Other: _____

Name and Number of Supplier: _____

MEDICATIONS:

	NAME	PURPOSE	DOSE/FREQUENCY
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

IHSN: Education Initiated re: ___ Care ___ Treatments ___ Medications

Plan of Care Initiated ___ Yes ___ No

Discharge Planning Initiated ___ Yes ___ No

