

Initial Assessment Form

Date: 1999, Oct 04

From: Elizabeth Woods ewoods

CLIENT ASSESSMENT FORM Date: _____

Time Started: _____ Location: _____

Time Completed: _____

Those Present: _____

NOTES:

Clients Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Medicare # _____

Private Insurance _____

Address _____

Policy # _____

Phone # _____

GAP Insurance _____

Doctors Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Type of Medicine Practiced: _____

Hospital: _____

Location: _____

Preferred Hospital: _____

Responsible Party: _____

Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Business Phone: _____

Next of Kin: _____

Address: _____

City: _____

State: _____

Home Phone: _____

Business Phone: _____

Do you have an Attorney ? _____

Name: _____ Phone: _____

Durable Power of Attorney ? : _____

Do you have a Will or Trust ? : _____

PHYSICAL

1) Do you have any physical disabilities that interfere with your activities ?

a) Poor Eyesight _____

b) Poor Hearing _____

2) Do you have any supportive devices ?

a) Cane _____

c) W/C _____

b) Walker _____

d) Hearing Aid _____

e) Other _____

3) Do you have any physical impairments or Chronic Illnesses

a) Heart Trouble _____ b) Arthritis _____

c) High Blood Pressure _____

d) Emphysema _____ Other _____

- 4) Do you have any difficulties completing daily household chores ?
- 5) Do you find it difficult getting down to clean floors and reach areas you use to reach ?
- 6) Do you have any trouble making your bed or changing your sheets ?
- 7) Do you find your vacuum cleaner too heavy or clumsy for you to use ?
- 8) Do general household chores take much of your energy ?
- 9) Are you able to get into and out of your shower or tub unassisted?
- 10) Is it hard to get into; or out of the tub or shower ?
- 11) Are Grabber Bars (needed) available on shower, tub, or any other areas ? _____
- 12) Do you have any difficulty with dressing ?
- 13) Do you routinely take medications ?

a) What are they _____

b) How often _____

- 14) Are you allergic to any medications ?

15) What method do you use to assure that you don't forget to take your medication, or that you don't take it too often ? _____

NUTRITIONAL NEEDS

1) Are you on a special diet for Medical reasons ?

2) What do you eat for a typical:

Breakfast _____

Lunch _____

Dinner _____

3) How often do you grocery shop ? _____

4) Do you do your own shopping, or does someone shop for you ? _____

5) Is it difficult for you to prepare full meals ? _____

6) Is it easier to just have a snack at mealtime instead of preparing a meal ? _____

7) Do you find food sometimes spoils before you are able to use it ? _____

8) Do you like most foods, or are you more choosy about what you eat ? _____

10) Do you enjoy meals more when someone else prepares them ? _____

11) Do you look forward to eating meals out with family or friends ? _____

12) Do you sometimes leave things cooking on the stove, and forget about it ? _____

13) Do you ever forget, and leave the water running ? _____

14) Do you ever let the tea pot run dry ? _____

15) Would you eat more often if you had someone to cook for you ? _____

16) Would you like someone to bring a hot meal to your home at noon-time ? _____

HOME SAFETY

1) Do you use an electric blanket, electric mattress pad or heating pad ? _____

2) Do you ever forget to turn the electric blanket, electric mattress pad, or heating pad off ?

3) Do you use throw rugs ?

4) How many sets of stairs are there in your home that you must climb each day ?

5) Are they difficult for you to climb ?

6) If you should fall, how would you get help ?

7) How many telephones do you have ? _____. Where are they located ?

8) Are emergency and family phone numbers readily available if you need them ?

9) Do you have dead-bolt locks on your doors ? _____. Do you keep your doors locked at all times ?

TRANSPORTATION

1) Do you drive a car ? _____. How often do you drive ? _____

2) Have you had any difficulties driving ?, such as traffic citations, accidents, etc. ?

3) Would you prefer not to drive if you could be taken to appointments and shopping by someone else .

4) Do you skip social functions, or change your plans because you don't feel like driving that day ?

MENTAL STATUS/MEMORY/JUDGMENT

1) What is your age ? _____ Birthdate ? _____

2) How many siblings do you have ? How many, are;(or were) older/younger ?

- 3) What is the name of our President ?
- 4) What is today's date ? Month - Day - Year ?
- 5) What are your children names and ages ?
- 6) When was your last Doctors' visit ?
- 7) What would you do if a stranger came to your door and asked to use your phone because their car broke down ?
- 8) Someone calls you on the phone and says they are the vice-president of your bank, and asks you to withdraw \$ 3000 to help them catch a bank employee who has been stealing from the Bank. What would you do ?

FINANCES

- 1) Do you write checks for monthly bills ?
- 2) Do you ever forget to send out a bill when it is due ? _____.
- 3) Is your monthly paperwork overwhelming ?
- 4) Would it be helpful if someone else took care of bill paying for you ?

HOUSEHOLD MAINTENANCE

- 1) Who does needed house repairs and yardwork ?
- 2) Would it be helpful if someone took care of them for you ?

SOCIAL

- 1) How many Church and Social groups do you belong to ?
- 2) On an average - how many times a week do you attend social functions, or church ?
- 3) How many times a week do you go out for lunch or shopping ? _____. With or without friends ?
- 4) How many times a week do you have visitors ? _____
- 5) Does time seem to go slowly for you ?
- 6) Do you ever feel alone or lonely ? _____

7) Do you sometimes wish you had someone to talk to that would really listen to you ?

8) Do you sometimes have trouble getting up in the morning, or find yourself sleeping later because you don't have a reason to get up ?

9) Do you think you would enjoy a Senior Center where you could go during the day and be involved in activities with other older adults like yourself ?

ADDITIONAL RELEVANT OBSERVATIONS: