Assessor: ______________________
Date: ___________ Time: ________
Commencement Date ____________

Client Assessment Form

Personal Information:

Clients Name: ___________________________ Age:_____ Date of birth: _________________

Medical Assessment:

Primary Diagnoses: ____

____

____

____

Secondary diagnoses: ____

____

____

Relevant medical / surgical information:

Date	Condition	Details of Treatment

Allergies/Sensitivities: ____

____

Skin Condition: ☐ Intact ☐ Redness ☐ Decubitus ulcer ☐ Excoriation

Diabetic: ______________ ☐ Insulin ☐ Oral hypoglycemic ☐ Diet controlled

Mental Status/Behavior:

Orientation: Time _______ Place_______ Person _______ Comments____________________________________

Progressive Disorientation _______________________ Transient Disorientation _______________________

Behaviour: ☐ Compliant to care ☐ Anxious ☐ Restless ☐ Agitated

Aggression: ☐ Verbal ☐ Physical ☐ Sexual

Inappropriateness: ☐ Verbal ☐ Social ☐ Sexual

Abuse: ☐ History of being abused ☐ History of being abusive

Risks: ☐Elopement ☐Falls ☐Aggression ☐Choking

Social/Family/Issues/Concerns: ____

____

____

____

____

Functional Status:

Transferring: ☐ Self ☐ Assist ☐ Total care **Feeding:** ☐ Self ☐ Assist ☐ Total care

Appetite: ☐ Good ☐ Fair ☐ Poor **Bathing:** ☐ Self ☐ Assist ☐ Bed

Meal Prep: ☐ Self ☐ Assist ☐ Total care **Appetite:** ☐ Good ☐ Fair ☐ Poor

Housework: ☐ Self ☐ Assist ☐ Total care

Toiletting: ☐ Self ☐ Assist ☐ Incontinent ☐ Bladder ☐ Bowel

Notes: ____

____

Sensory Perception:

Vision: ☐ Normal ☐ Impaired ☐ Blind ☐ Contacts ☐ Glasses

Hearing: ☐ Normal ☐ Impaired ☐ Deaf ☐ Hearing Aid

Speech: ☐ Normal ☐ Impaired ☐ Aphasic ☐ Language Spoken ____________________

Literacy: ☐ Literate ☐ Illiterate

Pain: ☐ None ☐ Acute ☐ Chronic ☐ Location ____________________________

Notes: ____

____

Activity:

Mobility: ☐ Independent ☐ Bedridden ☐ Assistance Required 1 2

Assistive Devices: ☐ Mechanical Lifts ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Other ____________

☐ Prosthetics ☐ Leg Brace ☐ Neck Brace ☐ Hearing Aid ☐ Other ____________

Limbs: Upper Limbs ☐ Normal ☐ Impairment (R / L) ☐ Tremor (R / L) ☐ Amputation (R / L) ☐ Prosthesis

Lower Limbs ☐ Normal ☐ Impairment (R / L) ☐ Tremor (R / L) ☐ Amputation (R / L) ☐ Prosthesis

Notes: ____

____

Nutrition:

Nutritional Status: Height _________ Weight __________ on ____________ (date)

Mouth: ☐ Own Teeth ☐ Partial ☐ Dentures (Up / Low) ☐ No Teeth ☐ Ulcers ☐ Infection ☐ Drooling

Feeding: ☐ Independent ☐ Supervision ☐ Assistance ☐ Total Feed ☐ Choking Problem ☐ Swallowing Problem

Diet: ____________________________________ Supplement: ____________________________________

Notes: ____

____

Elimination:

Bladder: ☐ Continent ☐ Incontinent ☐ Nocturia

☐ Indwelling Catheter ☐ Type and Size ________________ ☐ Insertion Date ____________

☐ In & Out Catheterization ☐ Type and Size ________________ ☐ Insertion Date ____________

☐ Ileoconduit ☐ Appliance de to be changed ________________________________

☐ Condom Drainage

Bowels: ☐ Continent ☐ Self Care ☐ Ostomy Care/Ostomy Type ____________________

☐ Incontinent ☐ Assist ☐ Date to be changed __________________________

☐ Constipation ☐ Total Care ☐ Mushroom Catheter Date Inserted ________________

☐ Diarrhea ☐ C. Difficile ☐ Type and Size ______________________________

Notes: ____

____

Medications:

Medication	Dosage	Frequency	Comments

Additional Information/Treatments:

____

____

____

____

Signed ____ Date ____________________

Print Full Name ________________________________

Title ____________________________________ License #: ______________________

1st Nurse Registry
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