Nurse Assessment Form

Assessor: _____
Date: _____
Time: _____
Initials: _____ Title: _____

Personal Information:

Client's Name: _____ Age: _____ Date of birth: _____

MEDICAL ASSESSMENT:

Primary Diagnoses:

_____
_____
_____

Secondary Diagnoses: _____
_____
_____

Diabetic: Yes __ No __ Diet __ Oral hypoglycaemic __ Insulin __ Blood Sugar Control: Good __ Poor __

_____

Relevant medical / surgical information:

Date	Condition	Details of Treatment/Hospitalisation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies/Sensitivities: _____
_____

RISK ASSESSMENT (Fill in after assessment is completed)

_____
_____
_____
_____
_____
_____

SOCIAL SUPPORT/FAMILY ISSUES:

_____
_____
_____
_____
_____

MENTAL STATUS/BEHAVIOUR

Orientation: Daytime _____ Place _____ Person _____ Night time _____

Cognition: Normal __ Mild Impairment __ Moderate Impairment __ Severe Impairment ___

Behaviour: Normal __ Anxious __ Agitated __ Depressed __ Hostile __ Confused __ Aggressive _____
Wandering __ Sundowning __ Safety hazard _____ Other _____

Mental Health History: History of being abused __ History of being abusive __ Substance Abuse _____

_____

_____

_____

_____

_____

_____

Alcohol Intake/Risks: _____

Smoking History/risks: _____

SENSORY PERCEPTION:

Vision: Normal __ Impaired __ Blind __ Right/Left Cataracts __ Peripheral Vision __ Contacts __ Glasses __

_____

Hearing: Normal __ Impaired __ Left/Right Deaf __ Left/Right Hearing Aid __

_____

Speech: Normal __ Impaired __ Mild/Medium/Severe No speech __ First language _____

_____

Understanding: Normal __ Impaired __ Mild/Medium/Severe Non-responsive __

_____

Usual method of communication: Speech __ Writing __ Lip-reading __ Sign language __

_____

FUNCTIONAL LIMITATIONS:

Ambulation: Self __ Self with Aids __ Assist x 1 __ Assist x 2 __ Total Care __ Aids required _____

_____

Upper body limitations: _____

_____

Lower body limitations: _____

_____

Transfers: Self __ Assist x 1 __ Assist x 2 __ Total Care __ Aids required: _____

_____

Bathing/Personal Grooming: Self __ Assist x 1 __ Assist x 2 __ Total care __ Aids required: _____

_____

Dressing: Self __ Assist x 1 __ Assist x 2 __ Total care __ Aids required: _____

_____

Oral Care/Teeth: Self __ Assist x 1 __ Aids required: _____

_____

NUTRITIONAL/FLUID INTAKE STATUS

Body Mass: Emaciated __ Thin __ Normal __ Overweight __ Obese __ Recent weight loss: Yes/No

_____

_____

Oral Status: Own Teeth __ Dentures __ Partials/Plate __ Tooth decay __ Pain __ Swallowing Problems __

Choking risk __ Excessive saliva __ Mouth ulcers/infection __ Dry mouth __

_____

Diet: Regular __ Soft __ Minced __ Puree __ Liquid __ High/Low protein __ High/Low calorie __

Supplements (eg Ensure) _____

Appetite: Very Poor __ Poor __ Normal __ Above Normal __ Recent change Yes/No _____

Eating: Self __ Minimal Assistance __ Assist x 1 __ Aids required _____ Special needs/Risks _____

_____

_____

_____

Fluid Intake: Oral/IV/SC __ Dehydrated __ Attempts to limit fluids __ Normal __ Above normal __

_____

Drinking: Self __ Minimal Assistance __ Assist x 1 __ Feeder cup __ Straw/Glass Cup ___

_____

ELIMINATION

Toileting: Self __ Assist x 1 __ Assist x 2 __ Total care __ Aids required _____

_____

Urinary function: Normal __ Incontinent __ Frequent/Occasional __ Frequency __ Urgency __ Nocturnia __

Total care __ Catheter __ External/Indwelling Aids/Actions required _____

_____

_____

Bowel Function: Normal __ Incontinent __ Frequent/Occasional __ Constipation __ Diahhrea/Loose ___

Total care __ Medication Regimen _____ Aids/Actions required _____

_____

_____

PAIN MANAGEMENT

No Pain **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **Worst Possible Pain**

Pain History:

Pain description (Sharp, jabbing, burning, aching, etc)

Locations

Radiation? Yes/No	**Radiation? Yes/No**

Onset and Duration: Morning __ Afternoon __ Evening __ Night __ With Movement __

What causes or increases the pain?

What decreases or helps the paint? (Medication, heat pad, change of position, etc.)

Pain expression/Client goals for self relief:

MEDICATION REGIMEN

Name _____ DOB _____

Medication	Dose	Times	Comments

Additional Information/Treatments:

_____

_____

_____

_____

Signed _____ Date _____

Print Name _____ Title _____

License # _____

1st Nurse Registry
2215 N. Military Trail, Suite O, West Palm Beach, FL 33409
Phone: 561-948-2010 Fax: 561-948-2012
Email: Office@1stNurseRegistry.com
www:1stNurseRegistry.com