RIGHT ACCORD
Private Duty-Home Health Care

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# Client Assessment Form

**Date:**

| | | |
|---|---|---|
| **First Name:** | **Middle Name:** | **Last Name:** |
| **Phone number:** | **Date of Birth:** | **Gender:** **Weight:** |
| **Email address:** | **Start of Service:** | **End of Service:** |

| | |
|---|---|
| **Address:** | **Billing address:** |

| | |
|---|---|
| **Emergency contact/next of kin:**<br>**Relationship:** **Date of birth:**<br>**Phone number: (h)** **( c )**<br>**Email address:** | **Emergency contact/next of kin:**<br>**Relationship:** **Date of birth:**<br>**Phone number: (h)** **( c )**<br>dff<br>**Email address:** fdgd |

| | |
|---|---|
| **Supervisor:** | **Ambulatory: YES** ☐<br>**NO** ☐ |
| **Referred by:** | **Client type: Private Pay by client:** ☐<br>**Private pay by other:** ☐<br>**Insurance company:** ☐ |
| **Physician Name:**<br>**Phone number(s):** | **Physician address:**<br>**Fax number:** |
| **Principal Diagnosis/Medical History:** | **DNR:**<br>**YES** ☐<br>**NO** ☐ |

**MEDICAL HISTORY:**
**ALZHEIMER's** ☐ **ARTHRITIS** ☐ **BLIND** ☐ **BP ISSUES** ☐ **BREATHING ISSUES** ☐ **CANCER** ☐ **CHRONIC PAIN** ☐ **DEMENTIA** ☐
**DIABETES** ☐ **FALLS** ☐ **HEARING ISSUES** ☐ **HEART ISSUES** ☐ **INCONTINENT** ☐ **MEMORY ISSUES** ☐ **PARALYSIS** ☐
**SPEAKING ISSUES** ☐ **STROKE** ☐ **TREMORS** ☐ **VISION ISSUES** ☐ **WOUNDS** ☐ **OTHER: -**
_____

| **Assessed by:** (print name) | **Date:** |
|---|---|
| | |

**MOBILITY** **INDEPENDENT** ☐
**Assist with ambulation** ☐ **Assist with transfers** ☐ **Bed/Chair only** ☐ **ROM exercises** ☐ **Standby assistance** ☐

**VISION LOSS** **NOT APPLICABLE** ☐
**Right eye** ☐ **Left eye** ☐ **Peripheral only** ☐ **Wears glasses** ☐ **Clean glasses** ☐ **PARTIAL VISION LOSS** ☐

**HEARING**
**Hard of hearing** ☐ **Wears hearing aid** ☐ **Is deaf** ☐ **NOT APPLICABLE** ☐

**DIET** **INDEPENDENT** ☐
**Normal** ☐ **Diabetic** ☐ **Low Sodium** ☐ **Liquid only** ☐ **Feeding assistance** ☐ **Meal preparation: Breakfast** ☐ **Lunch** ☐ **Dinner** ☐

**BATHING** **INDEPENDENT** ☐ **A.M.** ☐ **P.M.** ☐
**Partial** ☐ **Complete** ☐ **Tub** ☐ **Shower** ☐ **Sponge bath** ☐ **Sink** ☐ **Other:** _____

**SKIN CARE** **HAIR CARE** **INDEPENDENT** ☐
**Moisturizer** ☐ **Powder** ☐ **INDEPENDENT** ☐ **Wash and dry** ☐ **Wash and set** ☐ **Brush and comb** ☐

**ORAL CARE** **NAIL CARE** **INDEPENDENT** ☐
**Brush and floss** ☐ **Denture care** ☐ **INDEPENDENT** ☐ ☐ ☐ **lean** **File** ☐ **l care** ☐ **olish**

**SHAVING**
**Face** ☐ **Axilla** ☐ **Legs** ☐ **Electric razor** ☐ **Safety** ☐ ☐
**INDEPENDENT**

**DRESSING** **INDEPENDENT** ☐ **WEIGHING** **INDEPENDENT** ☐
**Self dress** ☐ **Help select clothes** ☐ **Assist with dressing** ☐ **Weigh client** ☐ **Frequency** _____

**TOILETING**
**Bathroom** ☐ **dpan** ☐ **Ur** ☐ **mmode** **C** **ge diapers**
**INDEPENDENT**

**TRANSPORT**
**Has own car for caregiver use** ☐ **Drives self** ☐ **Unable to drive** ☐ **Use of Caregiver's car** ☐ **Transport Waiver on file** ☐

**ASSISTANCE WITH MEDICATION**
**Yes** ☐ ☐ **No** **Assistance with Medication Informed Conser** ☐ **n file**

**HOUSEKEEPING**

**None** ☐ ☐ **Light** ☐ **Normal** **Special Instructions:** _____

**FUNCTIONAL LIMITATIONS**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **AMPUTATION** | ☐ | | **PARALYSIS** | ☐ | | **LEGALLY BLIND** | ☐ |
| **INCONTINENCE** | ☐ | | **ENDURANCE** | ☐ | | **DYSPNEA** | ☐ |
| **CONTRACTURE** | ☐ | | **AMBULATION** | ☐ | | **OTHER LIMITATION** | ☐ |
| **HEARING** | ☐ | | **SPEECH** | ☐ | | **DESCRIPTION:** | ☐ |

**ACTIVITIES PERMITTED**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **COMPLETE BEDREST** | ☐ | | **PARTIAL WEIGHT BEARING** | ☐ | | **WHEELCHAIR** | ☐ |
| **BEDREST BRP** | ☐ | | **INDEPENDENT AT HOME** | ☐ | | **WALKER** | ☐ |
| **UP AS TOLERATED** | ☐ | | **CRUTCHES** | ☐ | | **NO RESTRICTIONS** | ☐ |
| **TRANSFER BED/CHAIR** | ☐ | | **CANE** | ☐ | | **OTHER** | ☐ |
| **EXERCISES PRESCRIBED** | ☐ | | | ☐ | | **DESCRIPTION:** | ☐ |

**MENTAL STATUS**

**Oriented** ☐ **Forgetful** ☐ **Disoriented** ☐ **Agitated** ☐ **Comatose** ☐ **Depressed** ☐ **Lethargic** ☐ **Other: _____**

**PROGNOSIS**

**POOR** ☐ **GUARDED** ☐ **FAIR** ☐ **GOOD** ☐ **EXCELLENT**

| | | |
|---|---|---|
| **DME and SUPPORTIVE DEVICES:**<br>**YES** ☐ **NO** ☐ | **SAFETY MEASURES:**<br>FALL PRECAUTIONS | **PETS?:** **YES** ☐ **NO** ☐<br>**CAT** ☐<br>**DOG** ☐ **TYPE: _____** |
| **NUTRITIONAL REQUIREMENTS:** | **ALLERGIES:** **YES** ☐ **NO** ☐ | **SERVICES REQUESTED:** |

**SPECIAL INSTRUCTIONS:**

_____

_____

_____

_____

_____

_____

_____

**Assessed by:**

**Signature: _____** **Date: _____**
**(Assessed by)**

**********

**Authorized by:**

**RN Name: _____**
**(printed)**

**RN Signature: _____** **Date: _____**
**(signature)**