WOODSLAKE HOME CARE

Client Assessment Form

Date of Assessment	Person(s) Providing Assessment:	
Circumstances of Interview/Needing Care For:		
Name		
Address		
Phone Number(s)	Date of Birth	Age

Current Living Conditions

☐House ☐Apartment/Condo ☐ Facility

Notes:

Brief History

How long at current residence:	Where from:
Marital status ☐Married ☐ Anniversary ☐Widowed ☐ Single	Children:
Siblings: Sisters Brothers Living Deceased	Grandchildren: Great Grandchildren:
Military Service:	Previous occupation(s):
Notes:	

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Preferred Activities

Favorite activities currently able to do	Favorite activities currently not able to do
Hobbies	Member of clubs and organizations (specify meeting times)
Regular appointments/social engagements (specify) ☐ Hair ☐ Nails	Member of church (specify meeting times) Church leader (pastor, priest, rabbi, etc.)? ☐ yes ☐ no
Entertainment preferences (symphony, theater, movies or other)	Collections
Family in area? Visit how often?	Regular friends and visitors Visit how often?
Smoker Pets – types (dog/cat/fish) and names	Required care for pets Veterinarian's name and phone number

General Observations of Social Behavior

☐ Outgoing and active ☐ Reserved ☐ Withdrawn ☐ Other

Comments

Shopping and Errands

Who is currently doing the shopping	How often?

Other routine errands

Ambulation

☐ Walks without assistance ☐ Uses cane ☐ Uses walker ☐ Uses wheelchair

☐ Needs transfer assistance	Weight/Height	FALL RISK	Gait Belt

Supportive Devices

☐ Bedside Commode
☐ Hand Held Shower
☐ Mobility Cart
☐ Ramps
☐ Bed Rails
☐ Furniture Raised
☐ Hospital Bed
☐ Oxygen
☐ Shower Chair/Bench
☐ Transfer Board
☐ Grab Bars in Bathroom
☐ Lift Chair
☐ Raised Toilet Seat/Arm Rest
☐ Stairs/Multi Level Home
☐ _____

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Driving

☐ Able to drive ☐ Unable to drive ☐ Has own car for caregiver use

Auto insurance company	Policy number	Date policy expires

Is auto registration current?	Date of last car maintenance/tune-up
☐ yes ☐ no	

Meals

Special dietary concerns ☐ Salt Restriction ☐ Water Restriction ☐ Sugar Restriction

Time: Typically eats

_____ ☐ Breakfast _____

_____ ☐ Lunch _____

_____ ☐ Dinner _____

_____ ☐ Snacks _____

Who cooks?	Other food providers

Favorite foods	Favorite Dessert
_____	_____

Dressing

☐ Able to dress self ☐ Needs assistance

Bathing

☐ No assistance necessary _____

☐ Family will bathe _____

☐ Bathing assistance _____

☐ Monitoring only _____

☐ Compliant _____

☐ Non-compliant _____

Incontinence

☐ Yes ☐ No

☐ Bladder ☐ Bowel ☐ Able to self-identify and/or self-manage changing needs

Incontinence products in use

☐ Disposable Underwear ☐ Pads ☐ Other _____

Laundry

Who currently does laundry?	How often?
	Clothing Bedding

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Housekeeping

Who currently does housekeeping?	How often?

Areas in need of cleaning

☐ Countertops/Dishes ☐ Dusting ☐ Organize/Tidy ☐ _____

☐ Sweep/Mop/Vacuum ☐ Bathrooms ☐ Empty Trash ☐ _____

Sleep Habits

Bedtime	Arises

Describe

☐ Nocturnal wakening _____

☐ Daytime napping _____

Future Plans, Goals, Greatest Fears

Medical History

☐ Allergies_____ ☐ Alzheimer's ☐ Arthritis

☐ Blind ☐ Blood Pressure Issues ☐ Breathing Issues

☐ Cancer ☐ Chronic Pain ☐ Dementia

☐ Diabetes ☐ Falls/Balance ☐ Hearing Issues

☐ Heart Issues ☐ Incontinence ☐ Depends ☐ Pads ☐ Other_____

☐ Paralysis ☐ Parkinson's ☐ Recent Surgery

☐ Seizures ☐ Speaking Issues ☐ Stroke

☐ Tremors ☐ Vision Issues ☐ Wounds

Medical History Details (Recent surgery type, date, current impact on client's condition, etc.)

_____

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Medication Concerns (compliance, non compliance, reminder needs, etc)

Pharmacy

Location	Phone

Primary Care Physician

Name	Address
Phone	Nurse

Other Physician

Name	Address
Phone	Nurse

Other Physician

Name	Address
Phone	Nurse

Eye Sight

Poor vision ☐ Eyeglasses ☐ Readers ☐ Cataracts L ☐ R ☐ Glaucoma L ☐ R ☐

Eye doctor	Phone

Hearing

Hearing Aids yes ☐ no ☐	Hard of hearing yes ☐ no ☐

Dental

Dentist	Phone

Dentures yes ☐ no ☐ Partial yes ☐ no ☐ ☐ Needs work _____

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Psycho-Social Illness
☐ Dementia (describe symptoms)
☐ Alzheimer's (describe symptoms)
☐ Wandering (describe symptoms)
☐ Uses Life-Line Device Company
☐ Substance abuse (describe)
☐ Other (describe)

Legal Documentation
☐ Living Will ☐ Durable Medical Power of Attorney ☐ Durable Financial Power of Attorney
Advance Directives/DNR ☐ Chemical ☐ Compression ☐ None
Instructions

Long-Term Care Coverage		
☐ Yes ☐ No	Company	Phone
Policy #	% covered	% not covered

Emergency Instructions

☐ Call Hospice	Phone	Ask for
DNR ☐ Chemical ☐ Compression ☐ None	Document location	

In the event of an emergency the caregiver will call 911 and notify the home office. Which family members should we notify?

Name	Relationship	
Day Phone	Evening Phone	Cell Phone
Name	Relationship	
Day Phone	Evening Phone	Cell Phone

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Name		Relationship
Day Phone	Evening Phone	Cell Phone

☐ Call religious leader

Name		Religion
Day Phone	Evening Phone	Cell Phone

Determination

☐ Client is appropriate for home care

☐ Client is not appropriate for home care

Reason