

**PINNACLE**  
ASSISTED LIVING SERVICES  
Pre-Admission Assessment

**IDENTIFYING INFORMATION**

Resident Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Medicare: \_\_\_\_\_ Medicaid: \_\_\_\_\_

Current Address/ Facility Information: \_\_\_\_\_

\_\_\_\_\_

Current Pharmacy: \_\_\_\_\_

Reason for Moving: \_\_\_\_\_

<b>MCO:</b>	<b>Case Manager:</b>	<b>RN Case Manager:</b>

<b>Guardian:</b> Person/Estate	<b>Payee:</b>	<b>Other:</b>

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

**Current Providers**

PCP: \_\_\_\_\_

Psych: \_\_\_\_\_

Neuro: \_\_\_\_\_

Dental: \_\_\_\_\_

Eye: \_\_\_\_\_

Other (Specialist): \_\_\_\_\_

**ADLs**

Bathing: \_\_\_\_\_

Dressing: \_\_\_\_\_

Eating: \_\_\_\_\_

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Grooming: \_\_\_\_\_

Mobility and Transferring: \_\_\_\_\_

Oral Care: \_\_\_\_\_

Toileting: \_\_\_\_\_

**IADLs**

Finances: \_\_\_\_\_

Housekeeping: \_\_\_\_\_

Meal Prep: \_\_\_\_\_

Shopping: \_\_\_\_\_

Transportation: \_\_\_\_\_

**Medication Administration**

Diabetes Management: \_\_\_\_\_

Medication Management: \_\_\_\_\_

**Behavior Patterns**

Aggressive/Combative: \_\_\_\_\_

Choking: \_\_\_\_\_

Destructive/Abusive: \_\_\_\_\_

Self-Abusive Behavior: \_\_\_\_\_

Suicidal Tendencies: \_\_\_\_\_

Wandering: \_\_\_\_\_

Sleep Pattern: \_\_\_\_\_

**Physical Health**

Chronic Illness: \_\_\_\_\_

Eyesight: \_\_\_\_\_

Exercise: \_\_\_\_\_

Hearing: \_\_\_\_\_

Physical Disabilities: \_\_\_\_\_

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Nursing Procedures: \_\_\_\_\_

Pain Management: \_\_\_\_\_

Recurring Illness: \_\_\_\_\_

Restorative/Rehabilitative Care: \_\_\_\_\_

Short-term Illness: \_\_\_\_\_

**Mental Health**

Attitude: \_\_\_\_\_

Interaction: \_\_\_\_\_

Maturation: \_\_\_\_\_

Mental illness: \_\_\_\_\_

Self-Concepts: \_\_\_\_\_

Verbal: \_\_\_\_\_

**Social Participation**

Communication: \_\_\_\_\_

Community Contacts: \_\_\_\_\_

Education: \_\_\_\_\_

Family Contacts: \_\_\_\_\_

Interpersonal Relationships: \_\_\_\_\_

Leisure Time Activities: \_\_\_\_\_

Religion: \_\_\_\_\_

Vocation/Job: \_\_\_\_\_

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**Final Notes**

Assessment Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

Location of Assessment: \_\_\_\_\_

Other Participants: \_\_\_\_\_

Possible Facility: \_\_\_\_\_