Assessor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_

Time: \_\_\_\_\_\_\_\_

Commencement Date \_\_\_\_\_\_\_\_\_\_\_\_

Level: RN LPN PCW CG CS

**Medical Assessment Form**

**Personal Information:**

Clients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB::\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Medical Assessment:**

**Medical Diagnoses:**











**Relevant surgical information:**

Date Condition Details of Treatment









**Allergies/Sensitivities:** 

**Skin Condition:**  Intact  Redness  Decubitus ulcer  Excoriation  Other

Other issues explained:

Location of skin issue:

Wound measurements:

**Diabetic:** \_\_\_\_\_\_\_\_\_\_\_\_\_  Insulin  Oral hypoglycemic  Diet controlled

**Mental** **Status/Behavior:**

**Orientation:** Time \_\_\_\_\_\_\_ Place\_\_\_\_\_\_\_ Person \_\_\_\_\_\_\_ Situation \_\_\_\_\_\_\_ Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dementia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behaviors:** ☐ 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

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Condom Drainage

 Appliance to be changed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 UTI hx. Date of last UTI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bowels:**  Continent  Self Care  Ostomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Incontinent  Assist  Date to be changed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Constipation  Total Care  Type and Size \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Diarrhea  C. Difficile hx

**Notes:** 





**Medications:**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Frequency | Comments |
|  |  |  |  |



**Additional Information/Treatments:**





**Client or Guardian Authorization**

The information contained within this document is not shared with any third parties. The information is kept in the client’s home file and the company’s client file for as long as services are being rendered. Upon termination of services the document is destroyed in a timely manner or retained if required by law. The document is used as a guide and reference to essential client care information. The Client or Legal Guardian, by signing this document gives the company consent to collect the information contained herein and use for the specified purpose.

Signed Date