Non-Medical Home Care Assessment Form

This Non-Medical Home Care Assessment Form provides a structured way to assess client needs, ensuring personalized care in their own homes. The form allows for detailed information about daily living needs, mobility, and personal preferences to guide caregivers in providing care that is tailored to the client's well-being.

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Patient information			
Name:			
Date of birth:	Gender:		
Address:			
Phone number:	Email address:		
Emergency contact:			
Relationship:			
Caregiver information			
Assigned caregiver:			
Care agency (if applicable):			
Caregiver phone:			
Assessment date			
Date of assessment:			
Assessor's name:	Designation:		
. Client's health and daily living needs			
Medical history (if relevant for care context)			
Does the client have any chronic conditions?	If yes, list the conditions:		
☐ Yes No			
Mobility			
Does the client have any mobility issues?	Requires assistance with:		

Walking

Climbing stairs

☐ Transfers (e.g., bed to chair)

No

Mobility devices used:

☐ Yes

Personal care needs		
Bathing:	Dressing:	
☐ Independent	Independent	
☐ Requires assistance	☐ Requires assistance	
Grooming:	Toileting:	
☐ Independent	☐ Independent	
☐ Requires assistance	☐ Requires assistance	
Nutrition and meals		
Meal preparation:	Special diet requirements:	
☐ Independent		
☐ Requires assistance		
Requires assistance with eating?		
☐ Yes No		
Household chores		
Light housekeeping needed:	Assistance with laundry?	
☐ Yes No	☐ Yes No	
Home environment safety concerns:		
Medication management		
Is the client able to manage their own medications?	Medication management assistance needed?	
☐ Yes No	☐ Yes No	
Medication reminders required?		
☐ Yes No		

II. Social and emotional needs

Companionship and mental health			
Does the client require social interaction or companionship?	Emotional support needs:		
☐ Yes No			
Mental health concerns (e.g., anxiety, depression	on):		
Family support			
Does the client have family members actively involved in their care?	Primary family caregivers:		
☐ Yes No			
III. Daily schedule			
Typical daily routine			
Wake-up time:	Bedtime:		
Meal times:	Errands needed:		
Assistance needed:			
☐ Yes No			
IV. Care plan and goals			
Care goals			
What are the main goals for the client's non-medical home care?			

Strategies for achieving goals				
Discussed with	client and/or family:	Key strategies (e.g., enhancing mobility, promoting independence, emotional support):		
Respite care ne	eeds			
Is respite care caregivers?	required for the family	Schedule for respite care (if applicable):		
☐ Yes	No			
V. Emergency protocols				
Emergency cor	ntacts and information			
Emergency pro	tocols in place:	List of emergency contacts and numbers:		
☐ Yes	No			
Does the client have a reasonable-cost emergency response system in place (e.g., alert device)?				
☐ Yes	No			
Health emergency plan				
What to do in case of a medical emergency (e.g., call 911, notify family):				

Notes/additional information		
Client/family sign-off		
I agree with the care plan and assessment outlined a	bove:	
Client signature	Date	
Family member signature (if applicable)	Date	
Caregiver/assessor sign-off		
I have completed the assessment and reviewed it with	th the client and family:	
		

Date

Assessor signature