NON-MEDICAL ASSESSMENT

Consumer Name:	Phone:
Address:	
Physician Name:	Phone:
Responsible Party Name:	Phone:
Emergency Contact Name:	Phone:

ASSESSMENT

General Topics	Subject Matter	Action(S) Indicated
General Information		
Current Situation HX		
Recent Hospitalizations/ Health Problems		
Height & Weight	Weight Status: ____ Increase ____ Static ____ Decrease Recent WT Changes:	
Current Medications		
Need for Palliative Care	❑ Yes ❑ No	
Dental Care		
Vision		
Hearing		
Mental Health Status	❑ Alert ❑ Oriented ❑ Confused ❑ Disoriented ❑ Other: MEMORY: ❑ Intact ❑ Poor REASONING/JUDGMENT: ❑ Good ❑ Poor ❑ Unimpaired	
LIVING HABITS		
Smoking Habits	Consumer Smokes: ❑ Yes ❑ No If yes, Issue/Problem: ❑ Yes ❑ No	
Alcohol Consumption	Consumer Drinks: ❑ Yes ❑ No Issue/Problem: ❑ Yes ❑ No	

Special Dietary Requirements		
Allergies	❑ No ❑ Yes- specify	
Eating Habits Appetite	❑ Good ❑ Fair ❑ Poor	
COMMUNICATION		
Language/ Communication	Primary Language: Speaks/Understands English:❑ Yes ❑ No Can make needs known:❑ Yes ❑ No	
Speech		
Understanding	❑ Unimpaired ❑ Understands Simple Phrases Only ❑ Understands Key Words Only ❑ Understanding Unknown ❑ Not Responsive	

CONSUMER NAME: _____

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ABILITY TO COMPLETE ACTIVITIES OF DAILY LIVING		
Functional Limitations	❑ No ❑Yes-explain:	
Mobility	❑ Indep ❑ Unable ❑ Needs assist	
Ambulation	❑ Indep ❑ Unable ❑ Needs assist	
Transfers	❑ Indep ❑ Unable ❑ Needs assist	
Bathing	❑ Independent in Bathtub or Shower ❑ Independent with Mechanical Aids ❑ Requires Minor Assistance or Supervision: ❑ Getting In/Out of Tub/Shower ❑ Turning Taps On/Off ❑ Washing Back ❑ Requires Continued Assistance ❑ Resists Assistance	
Dressing	❑ Independent ❑ Supervision or Needs some occasional assist ❑ Periodic or Daily Assist Needed: Difficulty with:	
Grooming & Hygiene	❑ Independent ❑ Reminder, Motivation/or Direction ❑ Assistance with Some Things ❑ Requires Total Assistance ❑ Resists Assistance	
Eating	❑ Independent ❑Independent with Special Provision for Disability ❑ Intermittent Assist With:❑ Cutting Up/Pureeing Food ❑ Must Be Fed ❑ Resists Feeding	
Bladder Control	❑ Totally Continent ❑ Needs Routine Toileting or Reminder ❑ Incontinent occasionally ❑ Incontinent daily	

Bowel Control	❑ Total Control Needs Routine Toileting or Reminder ❑ No Bowel Control Due to Identifiable Factors ❑ Loses Bowel Control occasionally ❑ Loses Bowel Control daily	
Toileting	❑ Raised Toilet Seat or Commode ❑ Difficulty With Buttons, Zippers ❑ Needs Help with Aids (E.g. Catheter, Condom Drainage, etc.) ❑ Other:	
Movement	❑ Exercises Daily ❑ Type/Time/Distance: ❑ Recent Changes to Routine: ❑ Exercise Alone ❑ Exercises With Attendant	
ABILITY TO COMPLETE INSTRUMENTAL ACTIVITIES OF DAILY LIVING		
MealPrep	❑Independent❑ Able if Ingredients Supplied ❑Can Make/Buy Meals Diet is Inadequate ❑ Physically/Mentally Unable to Prepare Food ❑ Chooses Not to Prepare Food	
Housekeeping	❑ Independent ❑ Generally Independent But Needs Help With Heavier Tasks ❑ Can Perform Only Light Tasks Adequately ❑ Performs Light Tasks But Not Adequately ❑ Needs Regular Help and/or Supervision ❑ No Opportunity to Do Housework/Chooses Not to Do Housework	
Shopping	❑ Independent ❑ Can Shop if Accompanied ❑ Unable to Shop ❑ No Opportunity to Shop/Chooses Not to Shop ❑ Uses Private Vehicle ❑ Uses Taxi/Bus	
Transportation	❑ Independent ❑ Must be Accompanied ❑ Must be Driven ❑Physically or Mentally Unable to Travel ❑ Needs Ambulance for Transporting	
Telephone Use	❑ Independent ❑ Can Dial Well Known Numbers ❑ Answers Only ❑ Unable ❑ No Opportunity to Use Telephone/Chooses Not to	
ATTENDANTPROFILE		
Attendant	❑ Independent ❑ Needs Attendant: Frequency: ❑ Intermittent ❑ 24 hours ❑ Daytime ❑ Night ❑ Attendant Needs Met by: ❑Spouse ❑ Friend ❑ Family ❑ Not met	
SOCIAL PROFILE		
Living Arrangements	Where: With Whom: Adequate: ❑ Yes ❑ No	
Any Safety/health hazards	❑ No ❑ Yes-specify:	
Home Environmental Assessment:		

Living Companions	❑ Alone ❑ With Spouse/Partner ❑ With Adult Child ❑ With Child(ren) ❑ With Other Adult Male ❑ With Other Adult Female ❑ Principal Helper:	

Social Activities Involvement:		
Religion & Culture	Ethnicity: Religion: Actively Practicing: ❑ Yes ❑ No	
FINANCIAL PROFILE		
Financial Benefits	❑ Social Security ❑ State Income Supplement ❑ Veterans/Disability Pension ❑ Company Pension ❑ Other	
Managing Finances	❑ Self ❑ Spouse ❑ Family ❑ Friend ❑ Trustee ❑ Power of Attorney ❑ Other	
ADDITIONAL INFORMATION		
Other information that could impact the level of care/services required to meet needs.		

_____

Assessor Name/Title (Print)

_____

Assessor Signature Date

_____

Client or Client's Representative's Signature Date