Company Logo

ABC HOME CARE

CLIENT ASSESSMENT FORM

Personal Information

Date:

First Name	**Middle Initial**	**Last Name**

Address	City
State / Zip Code	Telephone

Birth Date	Age	Gender	Height	Weight	Hair Color
_____/_____/_____ MM DD YYYY		☐M ☐F			

Assessment Performed By	Other Parties Present / Title *(i/e: family members, Care Manager)*

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Date of spouse's death

Legal Status ☐ Responsible for Self ☐ Power of Attorney ☐ Guardian ☐ DNR Order – Location:

Name: Phone Number:

Medical Contact Information

Primary Care Physician	Telephone
Hospital Name & Address	Telephone
Specialist Physician *(Specify)*	Telephone
Hospital Name & Address	Telephone

Emergency Contact Information

Emergency Contact 1		Relationship	
Address			
City	State	Zip	Telephone

Emergency Contact 2		Relationship	
Address			
City	State	Zip	Telephone

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Living Situation

Current Living Situation & Conditions	
Significant Events *(Recent or Past)*	
Disability History *(When did activities become more difficult)*	
Originally From? Length of time at current home?	Other In-Home Providers? *(Name | Service | Phone #)* NOTES
Any Children? Is Family/Children in the Area? Visitation Frequency	Any Pets? *(Animal Type & Names)* Care Required for Pets? Veterinarian Contact Info

Activities

Hobbies	Previous Career/Occupation
Favorite Activities Currently Doing	Favorite Activities But Can't Do
Ongoing Social Activities	Clubs/Organization Membership
Friends & Visitors	Visitation Frequency
DRIVING	
☐ Currently able to drive	Vehicle Registration current? ☐ YES ☐ NO
☐ Unable to drive: *(check ONE below)* ☐ Client's car used for Transportation ☐ Caregivers car used for Transportation	Auto Insurance Company Policy # Date of last service

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Functional Assessment

Levels of Assistance:

0=Independent – Completes the task independently
3=Minimum Assistance – Occassional assistance or supervision may be necessary
6=Moderate Assistance – Assistance or supervision is always necessary
9=Maximum Assistance – Totally dependent on others

1. For each activity check the box indicating the assistance needed.
2. If assistance is needed, indicate the source of help *(be specific: spouse, family, friend, paid help, volunteer, professional)*
3. In the comments indicate the type of assistance provided and how often it's provided. Indicate if client needs further help.

ACTIVITIES OF DAILY LIVING

Activity	Ind. 0	Min. Assist 3	Mod. Assist 6	Max Assist 9	Primary Source of Help	Comments / Other Sources
Eating	☐	☐	☐	☐		
Bathing	☐	☐	☐	☐		
Grooming	☐	☐	☐	☐		
Dressing	☐	☐	☐	☐		
Toileting	☐	☐	☐	☐		
Mobility	☐	☐	☐	☐		
Transferring	☐	☐	☐	☐		

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Activity	Ind. 0	Min. Assist 3	Mod. Assist 6	Max Assist 9	Primary Source of Help	Comments / Other Sources
Laundry	☐	☐	☐	☐		
Meal Preparation	☐	☐	☐	☐		
Light Housework	☐	☐	☐	☐		
Heavy Housework	☐	☐	☐	☐		
Shopping/Errands	☐	☐	☐	☐		
Transportation	☐	☐	☐	☐		
Medication Mgmt	☐	☐	☐	☐		

Adaptive Equipment	Has	Has but Doesn't Use	Needs	Comments
Cane/Crutches/Walker	☐	☐	☐	
Wheelchair *(manual / power)*	☐	☐	☐	
Toilet Equip. *(commode / seat)*	☐	☐	☐	
Bathing Equip *(seat / grab bars)*	☐	☐	☐	
Hospital Bed *(power / manual)*	☐	☐	☐	
Hoyer Lift *(power / manual)*	☐	☐	☐	
Other:	☐	☐	☐	
Dentures	☐	☐	☐	
Diabetic Supplies	☐	☐	☐	
Incontinence Products	☐	☐	☐	
Medical Phone Alert	☐	☐	☐	
Other:	☐	☐	☐	

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Medical Diagnosis

Diagnosed medical conditions/diseases	
Memory *(describe)* ☐ Dementia ☐ Alzheimer's	☐ Wanders ☐ Uses electronic alert system Company: ☐ Other
Drug Use/Abuse *(describe)*	

Prescription Medications

Pharmacy Location		Phone #	
Prescription	Dosage	Time to Take	Doctor
Prescription	Dosage	Time to Take	Doctor
Prescription	Dosage	Time to Take	Doctor
Prescription	Dosage	Time to Take	Doctor
Prescription	Dosage	Time to Take	Doctor
Prescription	Dosage	Time to Take	Doctor
Prescription	Dosage	Time to Take	Doctor
Prescription	Dosage	Time to Take	Doctor
Prescription	Dosage	Time to Take	Doctor

Over the Counter Medications

Medication	Dosage	Frequency	Notes
Medication	Dosage	Frequency	Notes
Medication	Dosage	Frequency	Notes
Medication	Dosage	Frequency	Notes
Pharmacy Location		Phone #	

Medication Notes

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Nutrition

Typical Current Meals		
Breakfast	Lunch	Dinner
Snacks		
Favorite Foods:		

Eats fewer than 2 meals per day	☐ YES ☐ NO	**Special Notes/ Nutrition Concerns**
Eats few fruits, vegetables or milk products	☐ YES ☐ NO	
Drinks beer, wine or liquor daily/regularly	☐ YES ☐ NO	
Has tooth or mouth problems that makes it difficult to eat	☐ YES ☐ NO	
Has gained/lost 10 pounds in past 6 months	☐ YES ☐ NO	

Sleep Patterns

Wakes	Bedtime
Daytime Naps	Nocturnal Wakening

Fall Risk Screening

1. How many times have you fallen in the past year?	
2. Are you worried you might have a fall?	☐ Not at all ☐ A little ☐ Somewhat ☐ Very
3. Do you limit activities now because of fall-related concerns?	☐ Never ☐ Occasionally ☐ Sometimes ☐ Often
If client has NOT fallen in the past year, skip questions 4 & 5 below.	
4. Where have you fallen?	☐ Getting in & out of bed ☐ Bathroom ☐ Outside the home ☐ Kitchen ☐ Between the bed & the bathroom ☐ Other:
5. Can you say what makes you more likely to fall?	☐ Feeling dizzy/lightheaded ☐ Getting up too quickly ☐ Walking in darkness ☐ Certain Shoes ☐ Walking on certain surfaces ☐ Turns ☐ Stairs ☐ Dim Lighting ☐ Other:

Insurance

Long Term Care Coverage? ☐ YES ☐ NO Policy #:	Company: Phone #: Contact Agent:

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