



Consultant: _____ Eval. Date _____

Client Assessment Form "Top Page"

Client

Name: _____ Age: _____ Date: _____

Address: _____ State: _____ Zip: _____

Cell #: _____ Hm. #: _____ Other #: _____

Responsible Party

Name: _____ Relationship: _____

Address: _____ State: _____ Zip: _____

Cell #: _____ Hm. #: _____ Work #: _____

Fax #: _____ Email: _____

Responsible Party #2: _____

DC Planner: _____ Phone #: _____

Using Other Referral Services: _____ Area Desired: _____

Leaving: Hospital SNF Senior Residence Own Home Relatives home

Est. Start Date: _____ Est. Move-in date: _____

Type of Home: Assisted Living Board & Care Not Sure

Type of Room: Private Shared Studio 1 Bedroom 2 Bedroom

Financial:

Monthly Income: \$ _____ Savings: \$ _____ Budget: \$ _____/mo

Housing: Own Home Must Sell LTC Ins. Estimated Proceeds: \$ _____

Government Programs: SSI Medicare Part B Medi-Cal Other: _____

Primary Diagnosis: _____

Comments: _____

Senior Care of Sacramento

Client Assessment form

Client Name: _____ Age: _____ Height: _____ Weight: _____ D.O.B: _____

Primary Diagnosis: _____

Cognitive/Behavior

- Alert
- Periods of Agitation
- Periods of Confusion
- Anxiety
- Combative
- Sundowner's
- Verbally Abusive
- Requires Redirecting
- Wander Risk
- Signs of Depression
- Follows Directions
- Confusion:
- Physician Diagnosis:
- Alzheimer's
- Dementia

Memory

- Oriented to Name
- Oriented to Place
- Month/Year

Short Term

- Appears Okay
- Mild Loss
- Moderate Loss
- Severe Loss

Long Term

- Appears Okay
- Some Problems

Mobility/Transfer

- Independent
- Cane
- Walker
- Wheelchair
- Self Propels
- Stand by Assist
- 1 Person Assist
- 2 Person Assist
- Fall Risk
- Poor Safety Awareness

Notes _____

Neurological

- No problems Noted
- Parkinson's
- Multiple Sclerosis
- RS Weakness
- LS Weakness
- Paralysis
- Tia's (mini-strokes)
- Stroke:
- Seizure Disorder

Respiratory

- No Problems
- Shortness of Breath
- Pneumonia
- COPD
- Inhaler/Nebulizer
- Bronchitis/Asthma
- Oxygen 24/7 PRN
- Self-Administered
- Needs Help

Cardiovascular

- No Problems
- CHF
- Angina
- Hypertension (HBP)
- Atrial Fibrillation
- Edema
- Prior Heart Attack
- Prior Bypass
- Pacemaker
- Coronary Artery Disease

Toileting

- Independent
- Continent
- Periodic Accidents
- Briefs-Day
- Briefs-Night
- Incontinent-Bladder
- Incontinent-Dribble
- Incontinent-bowel
- Wears Pads
- Needs Urinal
- Needs Assistance Toileting

Bedtime/Sleeping

- Usually Sleeps Thru Night
- Irregular Habits
- Insomnia
- May Wake to use Toilet
- Toilet 2-3 times
- Needs Assist Toileting
- Uses Commode at Night

Feeding

- Feeds Self
- Needs Food Cut
- Soft Food
- Swallowing issues
- Chewing Issues
- Own Teeth
- Dentures
- Appetite:
- Normal Diet
- Special Diet (notes)
- Food Allergies

Notes _____

Bathing

- Independent
- Verbal Cueing
- Stand-by Assist
- Hands-on Assist
- Light
- Moderate
- Total

Groom/Dress

- Independent
- Verbal Cueing
- Stand-by Assist
- Hands-on Assist
- Layout Clothes
- Assist shaving
- Dental assistance

Hearing

- Adequate
- Fair
- Poor
- Wears Aids

Vision

- Adequate
- Fair
- Poor
- Glasses
- Glaucoma
- Cataracts
- Past Surgery
- Macular Degeneration
- Legally Blind

Diabetes

- None
- Controlled by Diet
- Oral Medication
- Self-Managed Insulin
- Assist w/insulin
- Self-Monitoring
- Assist Monitoring

Notes: _____

Senior Care of Sacramento

Client Assessment form

Client Name: _____

Skin Care

- Routine care
- Ointment for Skin
- Bruises
- Bruises Easily
- Dermal
- Stage: _____

Other (Medical)

- Arthritis
- Osteoporosis
- Fractures
- Medical Procedures Pending
- On Hospice

Other

- Smoker (no. a day _____)
- Alcohol Abuse
- History of Drug Abuse

Urinary/Ostomy

- Self-Manage Foley
- Catheter – Temp _____
- Assist Emptying Bag
- Self-Manage Ostomy
- Assistance with Ostomy
- Urinary Tract Infection

Notes _____

Medications:

Separate Page Attached

Drug Allergies: Yes

None Known

Dementia/Behavior Medications:

Primary Care Physician: _____

Family advised about Physician's report Yes No

Address: _____

Family Advised about TB test: Yes No

Financial:

Have durable power of attorney for: Health Care Financial Obtaining Conservator

Responsible Party #1:

Name: _____

Address: _____

Responsible Party #2

Name: _____

Address: _____

Client's Budget: SSI Adequate Other:
\$ _____/month _____

Client Miscellaneous:

Marital Status: _____ Date Of Birth: _____ Occupation: _____

Who takes to medical appointments: Facility Family Either Veteran Spouse of Veteran
 Applying for aid and attendance benefits

Client social and activity interests: _____
