

# *Shoreham Village Senior Citizens Association*

## *Assisted Living Assessment*

*This information is private and confidential and will only be shared with the Health Care Team.*

### **1. Profile:**

Name: \_\_\_\_\_ Health Card Number: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ Sex: \_\_\_\_\_ Religion: \_\_\_\_\_ Clergy: \_\_\_\_\_

Date of Birth: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Health Insurance: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_

POA: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_

Supporting Network (List children, family, neighbor(s) involved):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

**Person Finances/Banking:**

Independent: Yes \_\_\_\_\_ No \_\_\_\_\_ Power of Attorney: \_\_\_\_\_

Person Responsible for Bill Payment: \_\_\_\_\_

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

Home Phone: (     ) \_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_

Present living arrangement: Alone: \_\_\_\_\_ House: \_\_\_\_\_ Apartment: \_\_\_\_\_

**2. Diagnosis:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Health History:**

Any history of the following: (Please check)

- |                                  |                             |
|----------------------------------|-----------------------------|
| Osteoporosis _____               | Parkinson's _____           |
| Diabetes _____                   | Hypertension _____          |
| Emphysema/Bronchitis/COPD _____  | Edema _____                 |
| Stroke _____                     | Chest Pain _____            |
| Multiple Sclerosis _____         | Dizziness _____             |
| Heart/Circulatory Problems _____ | Shortness of Breath _____   |
| Epilepsy _____                   | Pain _____                  |
| Thyroid Disease _____            | Communicable Diseases _____ |
| Phobia _____                     | HIV _____                   |
| Anxiety _____                    | Clostridium Difficile _____ |
| Depression _____                 | VRE _____                   |
| Fractures _____                  | MRSA _____                  |
| Arthritis _____                  | Chicken Pox _____           |
| Cancer _____                     | Other _____                 |
| Mental Illness _____             | List Other: _____           |

Date of Pneumovax Vaccine: \_\_\_\_\_ Date of last Flu Vaccine: \_\_\_\_\_



**6. Medication Management:**

Independent: Yes \_\_\_\_\_ No \_\_\_\_\_  
Able to open vials: Yes \_\_\_\_\_ No \_\_\_\_\_  
Knows medication and their purpose: Yes \_\_\_\_\_ No \_\_\_\_\_  
Any missed doses: Yes \_\_\_\_\_ No \_\_\_\_\_  
Prepour Medications weekly: Yes \_\_\_\_\_ No \_\_\_\_\_  
Dosette \_\_\_\_\_ Blisterpack \_\_\_\_\_

**7. Allergies:**

Yes \_\_\_\_\_ No \_\_\_\_\_

Food: \_\_\_\_\_

Drug: \_\_\_\_\_

If yes, what is the reaction? \_\_\_\_\_

Other: \_\_\_\_\_

**8. Special Diet:**

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type \_\_\_\_\_

Supplements? \_\_\_\_\_

Texture modification: \_\_\_\_\_ cut up \_\_\_\_\_ ground \_\_\_\_\_ puree

Likes/Dislikes: \_\_\_\_\_

Swallowing ability: \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor

Chewing ability: \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor

Appetite: \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor

**9. Meal Preparation:**

Snacks: Yes \_\_\_\_\_ No \_\_\_\_\_  
Full Meals: Yes \_\_\_\_\_ No \_\_\_\_\_

Nutritional Needs: Lunch \_\_\_\_\_ Supper \_\_\_\_\_

Diet includes:  
Grain products \_\_\_\_\_  
Fruits & vegetables \_\_\_\_\_  
Milk products \_\_\_\_\_  
Meats / substitutes \_\_\_\_\_

Special eating utensils: \_\_\_\_\_rimmed plate \_\_\_\_\_special glass \_\_\_\_\_special utensils

Comments: \_\_\_\_\_

**10. Weight & Height:**

Weight \_\_\_\_\_ Height \_\_\_\_\_

Recent changes in weight? Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_

**11. Teeth:**

Own \_\_\_\_\_ None \_\_\_\_\_ Problems: Yes \_\_\_\_\_ No \_\_\_\_\_

**Dentures:**

Upper \_\_\_\_\_ Lower \_\_\_\_\_ Both \_\_\_\_\_ Partial Plate \_\_\_\_\_

Dentist: \_\_\_\_\_

**12. Vision:**

Problems: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain \_\_\_\_\_

Glasses/Contacts: Yes \_\_\_\_\_ No \_\_\_\_\_

***Optometrist/Ophthalmologist:***

Name: \_\_\_\_\_

Last Visit: \_\_\_\_\_

Comments: \_\_\_\_\_

***13. Hearing:***

Problems:            Yes \_\_\_\_\_            No \_\_\_\_\_

If yes, describe: \_\_\_\_\_

Hearing Aid        Right \_\_\_\_\_        Left \_\_\_\_\_

Hearing Test: \_\_\_\_\_

***14. Skin Condition:***

Dry \_\_\_\_\_        Ulcers \_\_\_\_\_        Rashes \_\_\_\_\_        Bruises \_\_\_\_\_        Skin Tears \_\_\_\_\_  
Other \_\_\_\_\_

Comments: \_\_\_\_\_

***15. Foot Care:***

Able to cut own nails:    Yes \_\_\_\_\_            No \_\_\_\_\_

If no, who provides foot care? \_\_\_\_\_

Requests Foot Care:    Yes \_\_\_\_\_            No \_\_\_\_\_

***16. Mobility:***

Independent:            Yes \_\_\_\_\_            No \_\_\_\_\_

Balance \_\_\_\_\_    Able to Climb \_\_\_\_\_    Joint Pain \_\_\_\_\_    Stairs \_\_\_\_\_

Cane \_\_\_\_\_        Walker \_\_\_\_\_        Wheelchair \_\_\_\_\_        Personal Assistance \_\_\_\_\_

Comments: \_\_\_\_\_

**17. Transferring:**

Independent: Yes \_\_\_\_\_ No \_\_\_\_\_

Need bars in bathroom \_\_\_\_\_

Equipment: \_\_\_\_\_

Comments: \_\_\_\_\_

**18. Bathing:**

Independent: Yes \_\_\_\_\_ No \_\_\_\_\_

Type: Sponge \_\_\_\_\_ Bed \_\_\_\_\_ Tub \_\_\_\_\_ Shower \_\_\_\_\_

Requests assistance with weekly bath: Yes \_\_\_\_\_ No \_\_\_\_\_

Equipment: \_\_\_\_\_

Comments: \_\_\_\_\_

**19. Dressing/Undressing:**

Independent: Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_

**20. Personal Care:**

Any assistance at home for personal Care Yes \_\_\_\_\_ No \_\_\_\_\_

Any change in need for assistance in the last three (3) months Yes \_\_\_\_\_ No \_\_\_\_\_

Able to make own bed Yes \_\_\_\_\_ No \_\_\_\_\_

**21. Sleep Habits:**

Problems: Yes \_\_\_\_\_ No \_\_\_\_\_ Supervision at night Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_

**22. Bowel Habits:**

Continent \_\_\_\_\_ Incontinent \_\_\_\_\_

Constipation Yes \_\_\_\_\_ No \_\_\_\_\_

Occasional Incontinence Yes \_\_\_\_\_ No \_\_\_\_\_

Independent with Supplies and Equipment Yes \_\_\_\_\_ No \_\_\_\_\_

Needs Assistance Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_

**23. Bladder Habits:**

Continent \_\_\_\_\_ Incontinent \_\_\_\_\_

Occasional Incontinence Yes \_\_\_\_\_ No \_\_\_\_\_

Independent with Supplies and Equipment Yes \_\_\_\_\_ No \_\_\_\_\_

Needs Assistance Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_

**24. Memory/Orientation:**

Able to perform all or most steps in a multitask sequence: Yes \_\_\_\_\_ No \_\_\_\_\_

Oriented \_\_\_\_\_

No Memory Loss \_\_\_\_\_

Disoriented To: Time \_\_\_\_\_ Place \_\_\_\_\_ Person \_\_\_\_\_

Forgetful \_\_\_\_\_

Poor Short Term Memory \_\_\_\_\_

Poor Long Term Memory \_\_\_\_\_

Confused to Task Intermittent \_\_\_\_\_ Marked \_\_\_\_\_

Attention Span: Good \_\_\_\_\_ Short \_\_\_\_\_ Poor \_\_\_\_\_

Able to make decisions about organizing day: Eg. When to get up, have meals, get dressed, and activities: Independent \_\_\_\_\_ Impaired \_\_\_\_\_

Comments: \_\_\_\_\_

**25. Cooperation/Compliance:**

Concerns: Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_

**26. Judgment:**

Concerns: Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_

**27. Behavior:**

Compulsive _____	Other _____	
Restless _____	Day _____	Night _____
Agitated _____	Day _____	Night _____
Aggressive _____	Physical _____	Verbal _____

What precipitates anger or aggression? \_\_\_\_\_

Comments: \_\_\_\_\_

**28. Safety Concerns:**

Use of Stove/Oven _____	Substance Use/Abuse _____	Falls in last (5) Months _____
Smoking _____	Other _____	

Comments: \_\_\_\_\_

**29. Tendency to Wander:**

Inside	Day _____	Night _____
Outside	Day _____	Night _____

**30. Communication:**

Concerns: Yes _____	No _____	
Able to make self understood	Yes _____	No _____

Comments: \_\_\_\_\_

**31. Social History/Activity Interests:**

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**32. Social Interaction:**

Concerns: Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_

**33. Vehicle:**

Yes \_\_\_\_\_ No \_\_\_\_\_

**34. Summary:**

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**35. Care Requirements:**

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