

# Assessment Questionnaire

This assessment sheet is meant to be of assistance in determining long-term care solutions. It is meant to “take stock” of what a person’s needs might be, and what the projected care needs are based on lifestyle, genetics, current health (mental and physical), and support systems. This questionnaire is similar to an assessment done by a geriatric care professional, and is intended as information gathering only for the non-professional and a means of starting a process for determining care needs and the best course of action based on projections by a professional.

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## History

Social \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Educational/vocational \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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Mental health \_\_\_\_\_

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Current social/family support system \_\_\_\_\_

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## Functional Assessment

Medical problem list:

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

Current medications (name, dose and purpose):

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

Hospitalization/surgery history \_\_\_\_\_

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Special diet \_\_\_\_\_

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Special equipment or therapy \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Sensory/expressive impairment \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Auditory \_\_\_\_\_

\_\_\_\_\_

Visual \_\_\_\_\_

\_\_\_\_\_

Speech \_\_\_\_\_

\_\_\_\_\_

### Functional Capabilities

Answer "Yes" if person can functionally perform the task.

Control of bowel and bladder       Yes     No    \_\_\_\_\_

Management of toileting at night       Yes     No    \_\_\_\_\_

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

Transferring to bed, chair, toilet, etc.       Yes     No    \_\_\_\_\_

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

Eating       Yes     No    \_\_\_\_\_

Preparing meals       Yes     No    \_\_\_\_\_

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

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

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

Taking medication       Yes     No    \_\_\_\_\_

Reaching light switches       Yes     No    \_\_\_\_\_

Ability to use phone       Yes     No    \_\_\_\_\_

Housekeeping, laundry       Yes     No    \_\_\_\_\_

- Managing home repairs  Yes  No \_\_\_\_\_
- Money management  Yes  No \_\_\_\_\_
- Ability to respond in emergency  Yes  No \_\_\_\_\_

### Living Situation

- Marital status:  Married  Widowed  Single  Divorced
- Household occupants  Yes  No \_\_\_\_\_
- Access to grocery, drug store  Yes  No \_\_\_\_\_
- Public transportation  Yes  No \_\_\_\_\_
- Family composition \_\_\_\_\_
- Floor plan of house \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Neighborhood \_\_\_\_\_  
\_\_\_\_\_

### Home Safety Assessment Do the following meet safety requirements?

- Carpeting and rugs  Yes  No \_\_\_\_\_
- Bathtub safety devices  Yes  No \_\_\_\_\_
- Adequate lighting  Yes  No \_\_\_\_\_
- Flooring  Yes  No \_\_\_\_\_
- Furniture  Yes  No \_\_\_\_\_
- Cane/walker safety  Yes  No \_\_\_\_\_
- Railings/grab bars  Yes  No \_\_\_\_\_
- Smoke alarms  Yes  No \_\_\_\_\_
- Posted emergency number  Yes  No \_\_\_\_\_
- Stove/cooking safety  Yes  No \_\_\_\_\_
- Access in/out of house  Yes  No \_\_\_\_\_
- Home security systems  Yes  No \_\_\_\_\_
- Are there:** Fire hazards  Yes  No Exposed pipes, radiators, cords  Yes  No

## Cognitive Function

Orientation to time, place and people \_\_\_\_\_

\_\_\_\_\_

Short-term memory \_\_\_\_\_

\_\_\_\_\_

Long-term memory \_\_\_\_\_

\_\_\_\_\_

Language skills \_\_\_\_\_

\_\_\_\_\_

Visual/spatial skills \_\_\_\_\_

\_\_\_\_\_

Reasoning/judgment \_\_\_\_\_

\_\_\_\_\_

Insight \_\_\_\_\_

\_\_\_\_\_

Executive function \_\_\_\_\_

\_\_\_\_\_

Motor skills \_\_\_\_\_

\_\_\_\_\_

## Psychological Function

Presentation/appearance \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Mood/affect** \_\_\_\_\_

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**Anxiety** \_\_\_\_\_

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**Psychotic symptoms** \_\_\_\_\_

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Delusions \_\_\_\_\_

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Hallucinations \_\_\_\_\_

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Agitation \_\_\_\_\_

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**Behavioral disturbance** \_\_\_\_\_

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## Financial Situation

**Assets** \_\_\_\_\_

**Income** \_\_\_\_\_

**Long-term care insurance coverage** \_\_\_\_\_

**Legal information:**    Living will    Health care surrogate    POA    Guardian \_\_\_\_\_

**Entitlements** (Social Security, pension) \_\_\_\_\_

Please contact **Live Free Home Health Care** for more information on how to use this information and what care needs are required based on the information gathered.