HOME HEALTH SOLUTIONS GROUP
HOME COMPANION SERVICES

NURSING ASSESSMENT FORM

__ Start of Care **___ Recertification** **___ Resumption of Care**

Date: ______________ **RN:**:____

Client:____ MR#_________

Primary diagnosis:____

Second diagnosis:____

Height:______ **Weight**:______ **Temp**:______ **Pulse**:_____ **Resp**:______ **B/P**:________

Allergies:____________________________________ **Gender**: __male __female

Diet:____

Past history:____

____

Psychosocial Status

Mental Status: Oriented X ______________ Disoriented X ______________________
__Comatose __forgetful __Agitated __Confused __anxious __depressed
Comment:____

Risk Factors::
___smoking __obesity ___alcohol dependency __drug abuse __none of the above

NURSING ASSESSMENT FORM (Cont.)

Client: ____ MR# __________

Functional limitations: __Amputation ____________ __ Bowel/Bladder incontinence __contracture __hearing __paralysis __endurance __ambulation __speech __vision __poor manual desterity __legally blind __dyspnea __poor hand-eye coordination __unsteady gait __poor balance other:_______________________________________
____

Activities permitted: __complete bedrest __bedrest/BRP __up as tolerated __transfer bed to chair __independent in home

Assistive device: __cane __quad cane __walker __ rolling walker __reg. wheelchair __electric wheelchair __crutches other____________________________________

Equipment at home: __hospital bed __commode __hoyer lift __nebulizer __bath bench __ apnea machine __oxygen concentrator __suction machine other____

Device/equipment needed at home:____

Significant other:____
____

Cardiovascular: __client denies problems
__chest pain __palpitations __vertigo __syncope __pulse deficit __PVD
__cyanosis __claudication __varicose veins __murmur __fatigue
__cardiac pacemaker date__/__/__ last date checked__/__/__ type:_____________
__edema:___________________________ other:________________________________

Respiratory: __client denies problems
Lung: __clear __left __ right (wheezes/rhonchi, crackles/rales, diminish /absent)
Capillary refill less than 3 sec/ great than 3 sec, __orthopnea __hemoptysis
__SOB at rest/minimal exertion/moderate exertion/when walking more than 20 feet
__cough productive/non-productive describe:__________________________________
Oxygen @ __ LPM via nasal cannula/mask/trach trach size/type:_________________
Other:____

Skin: __client denies problems
Color: __pink __pale __cyanotic __jaundiced Turgor: __poor __good
Temperature: __hot __warm __cool Condition: __dry __moist __ecchymosis
__rasch __petechie __itch __redness __ bruises __scaling
Comment:____
Open wound/decubitus/incision/diabetic ulcer location:___________________________

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NURSING ASSESSMENT FORM (Cont.)

Client: ____ **MR#** __________

Gastrointestinal/abdomen: __client denies problems
__heartburn __distention __flatulence __nausea __vomiting __constipation __ascites
__cramping __bleeding __anorexia __dysphagia __diarrhea __bowel incontinence
Bowel sounds:________________ Last BM:______________________
Ostomy: ___________________ stoma:____
Other:____

GU/GYN: __client denies problems
__frequency __urgency __incontinence __nocturia __polyuria __dysuria __oliguria
__pain __burning __odor __lithiasis __ hematuria __infections
ostomy:____
Catheter:__condon cath __foley cath __suprapubic cath size:____F with ____cc
__mastectomy R/L __hysterectomy __Vaginal bleeding __discharge ___BPH/TURP
Other:____

Neurology: __client denies problems
__headache __fine/gross hands tremor __PERRLA L/R ___dominant side R/L
__aphasia __hemiplegia __paraplegia __quadriplegia __numbness __tinting
__seizures __ataxia __syncope __vertigo __dizziness __weakness
Other:____

Musculoskeletal: __client denies problems
__fracture:__________________ ___contracture joints:_________________________
__atrophy:__________________ ___decreased ROM:___________________________
Pain: location:________________________________ intensity:1 2 3 4 5 6 7 8 9 10
Duration: _less often than daily __daily, but not constantly __all of the time

Eye: __client denies problems
__impaired vision __cataracts R/L __retinopathy __blind R/L __legally blind
__glasses __contacts R/L ___blurred vision __prothesis R/L __glaucoma
Other:____

Nose: __client denies problems
__congestion __epistaxis __loss of smell __sinus problem
Other:____

Throat: __client denies problems
__dysphagia __hoarseness __lesions __sore throat
Other: ____

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NURSING ASSESSMENT FORM (Cont.)

Client: ____ **MR#** ___________

Mouth: __client denies problems
___dentures upper/lower/partial/total ___gingivitis __toothache ___ulcerations
Other: ____

Activities of Daily Living	Unable To do	Minimal assistance	Moderate assistance	Maximal assistance	independent
Ambulation					
Stairs					
Dressing					
Feeding					
Household tasks					
Transfer					
Self-care(grooming/bath)					
Toiling					

________________________________ ________________________________
History given by Relationship to client

________________________________ ________________________________
RN signature Date