

Client Assessment Form

Client's Name: _____

<p>Activities Permitted:</p> <ul style="list-style-type: none"> <input type="checkbox"/> No Activity Restrictions <input type="checkbox"/> Up As Tolerated <input type="checkbox"/> Independent at Home <input type="checkbox"/> Transfer With Assistance <input type="checkbox"/> Transfer to bed/chair <input type="checkbox"/> Partial Weight Bearing <input type="checkbox"/> Bedrest/Up to Bathroom <input type="checkbox"/> Complete Bedrest <input type="checkbox"/> Up with Cane/Crutches <input type="checkbox"/> Up with Walker <input type="checkbox"/> Uses Wheelchair <input type="checkbox"/> Exercises Prescribed <input type="checkbox"/> Supervised Outings <input type="checkbox"/> Other _____ <p>Allergies:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Adhesives <input type="checkbox"/> Environmental <input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> Pets <input type="checkbox"/> Smoke <input type="checkbox"/> Other _____ <p>Diet:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Regular Diet <input type="checkbox"/> Special Diet <input type="checkbox"/> Nothing by Mouth <input type="checkbox"/> Fluids only <input type="checkbox"/> On Intake/Output <input type="checkbox"/> Other _____ <p>Medical Equipment:</p> <p>Goals:</p>	<p>Functional Limitations:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ambulation <input type="checkbox"/> Amputation <input type="checkbox"/> Bowel/Bladder Incontinence <input type="checkbox"/> Contracture <input type="checkbox"/> Short of Breath w/ Min. Exertion <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Legally Blind <input type="checkbox"/> Paralysis <input type="checkbox"/> Speech Impairment <p>Other Limitations:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ambulation-Cane <input type="checkbox"/> Ambulation-Crutches <input type="checkbox"/> Ambulation-Walker <input type="checkbox"/> Ambulation-Wheelchair <input type="checkbox"/> Client Condition-Palliative <input type="checkbox"/> Client Condition-Stable <input type="checkbox"/> Client Condition-Unstable <input type="checkbox"/> Risk of Falls <input type="checkbox"/> Hearing Loss-Left Side <input type="checkbox"/> Hearing Loss-Right Side <input type="checkbox"/> Paralysis-Left Side <input type="checkbox"/> Paralysis-Right Side <input type="checkbox"/> Physical Weakness <input type="checkbox"/> Swallowing Difficulty <input type="checkbox"/> Vision Impaired –Left / Right <p>Mental Status:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Normal <input type="checkbox"/> Agitated <input type="checkbox"/> Aggressive <input type="checkbox"/> Cognitive Impairment (Alzheimer) <input type="checkbox"/> Comatose <input type="checkbox"/> Confused (Total / Intermittent) <input type="checkbox"/> Depressed <input type="checkbox"/> Disoriented to (Person/Place/ Time) <input type="checkbox"/> Forgetful/Needs Reminding <input type="checkbox"/> Lethargic <input type="checkbox"/> Violent Outbursts <input type="checkbox"/> Wandering 	<p>Care Orders:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Activities of Daily Living <input type="checkbox"/> Bowel Routine <input type="checkbox"/> Companionship <input type="checkbox"/> Dressing <input type="checkbox"/> Encourage Exercise/Range of Motion <input type="checkbox"/> Encourage Fluids/Nutrition <input type="checkbox"/> Enteral Feeding <input type="checkbox"/> Eye Care <input type="checkbox"/> Foot Care <input type="checkbox"/> Grocery Shopping <input type="checkbox"/> Housekeeping <input type="checkbox"/> Hygiene / Personnel Care <input type="checkbox"/> Laundry <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Medication-Administration <input type="checkbox"/> Medication-Assistance <input type="checkbox"/> Minimize Risk of Falls <input type="checkbox"/> Mouth Care <input type="checkbox"/> Nail Care <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Palliative Care <input type="checkbox"/> Pet Care <input type="checkbox"/> Provide Comfort Measures <input type="checkbox"/> Provide Stimulation-Mental <input type="checkbox"/> Provide Stimulation-Physical <input type="checkbox"/> Reminisce About the Past <input type="checkbox"/> Toileting Routine <input type="checkbox"/> Tracheotomy Care <input type="checkbox"/> Urinary Catheter Care <input type="checkbox"/> Vital Signs <p>Prognosis:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <p>Condition:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Stable <input type="checkbox"/> Unstable <p>Safety Measures Required:</p>
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