Compassion Care In-Home Health

New Client Assessment Form

Today's Date:

Name of Person Completing Form:

Client First and Last Name:

Your Email: (You will be emailed a copy of this form with the email provided here):

Choose Most Relevant Answers:

1. **Allergies:**

   ☐ Food ☐ Medicine ☐ Reactions ☐ Other/EpiPen

2. **Allergy/ Sensitivities:**

   ☐ Skin ☐ Breathing ☐ Eyes ☐ Other/ List

3. **Alcohol:**

   ☐ Beer ☐ Wine ☐ Liquor ☐ Other ☐ Never

4. **Alcohol Consumption:**

   ☐ Daily ☐ Weekly How many years? ☐ Other ☐ Never

5. **Appetite:**

   ☐ Good ☐ Fair ☐ Poor ☐ Recent Changes

6. **Assistive Devices:**

   ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair

7. **Assistive Devices:**

   ☐ Hoyer ☐ Mechanical Lift ☐ Slide-Bar ☐ Other/ List

8. **Behavioral:**

   ☐ Depression ☐ Normal ☐ Withdrawn ☐ Other/List

9. **Bladder:**

   ☐ Continent ☐ Incontinent ☐ Nocturia ☐ Catheter

10. **Blood Pressure:**

☐ Low/ Fainting ☐ High/ Controlled ☐ Normal ☐ Other/ Uncontrolled

11. **Body Limitations:**

☐ Paralysis L/ R ☐ Upper/Lower ☐ Weakness L/ R ☐ Other/ List

12. **Body Mass:**

☐ Emaciated/ Thin ☐ Normal ☐ Overweight/ Obese ☐ Other/ List

13. **Body Swellings:**

☐ Hand ☐ Feet ☐ Abdominal ☐ Other/ List

14. **Bowels:**

☐ Continent ☐ Incontinent ☐ Assist ☐ Self-Care

15. **Bowel Issues:**

☐ Constipation ☐ Diarrhea ☐ Ostomy ☐ Other

16. **Bowel Colors:**

☐ Bloody Stools ☐ Black Stools ☐ Normal Color ☐ Other

17. **Breathing Patterns:**

☐ Difficulty ☐ Shortness ☐ Normal ☐ Other

18. **Caffeinated Beverages:**

☐ Coffee/Tea/Soda How many daily How many years ☐ Other

19. **Cognition:**

☐ Impaired ☐ Mild/Moderate ☐ Normal ☐ Severe

20. **Cold:**

☐ Hands ☐ Feet ☐ Cold Sweats ☐ Other

21. **Communication:**

☐ Speech ☐ Writing ☐ Body Gestures ☐ Sign Language

22. **Coordination:**

☐ Lack of ☐ Normal ☐ Other

23. **Cough:**

☐ Asthma/ Wheeze ☐ Blood ☐ Phlegm ☐ Dry/Hacking

24. **Culture Factors:**

☐ Involved ☐ Lack of/ Missing ☐ Wants more ☐ Other

25. **Diabetic:**

☐ Insulin ☐ Oral Meds ☐ Diet Controlled ☐ Other

26. **Diet:**

☐ Regular/ Anything ☐ Diabetic/ Carbs ☐ Low Fat/Low Salt ☐ Supplement/ Other

27. **Diet:**

☐ Soft ☐ Puree ☐ Liquid ☐ Normal

28. **Dizziness:**

☐ Disease/Illness ☐ Medication ☐ Other/List

29. **Ears:**

☐ Ringing ☐ Discharge ☐ Pain ☐ Other

30. **Eyes:**

☐ Blurred ☐ Night Blindness ☐ Color Blindness ☐ Other

31. **Feedings:**

☐ Self ☐ Assist ☐ Total Assist ☐ Other

32. **Feedings Hazards:**

☐ Choking ☐ Swallowing ☐ Thickenings ☐ Other

33. **Financial Management:**

☐ Capable ☐ Needs Guidance ☐ Incapable ☐ Other

34. **Fluid Intake:**

☐ Dehydrated ☐ Normal ☐ IV ☐ Other

35. **Gastrointestinal:**

☐ Bloating/Gas ☐ Nausea ☐ Vomiting ☐ Other

36. **Hair Issues:**

☐ Dandruff ☐ Itching ☐ Hair Loss ☐ Other

37. **Headaches:**

☐ Concussion ☐ Migraines ☐ Sinus ☐ Other

38. **Hearing Impairments:**

☐ Deaf Left / Right ☐ Hearing Aid L/ R ☐ Normal L/ R ☐ Other

39. **Housing:**

☐ Home ☐ Apartment ☐ Friend ☐ Other

40. **Illicit Drugs:**

☐ Marijuana ☐ Cocaine/Crack ☐ Meth ☐ Other/ List/ Never

41. **Illicit Drugs Frequency:**

How often How many years With whom Other/ List/ Never

42. **Inappropriateness:**

☐ Verbal ☐ Social ☐ Sexual ☐ Other/ List/ None

43. **Irregular Heartbeat:**

☐ Brady/ Slow ☐ Tacky/ Fast ☐ None ☐ Other/ List

44. **Judgement:**

☐ Adequate ☐ Good ☐ Poor ☐ Other/ List/ Example

45. **Literacy:**

Read/What Level Write/What Level Other

46. **Loss of Balance:**

☐ Dizziness ☐ Earache ☐ Vertigo ☐ Other/ List

47. **Memory:**

☐ Good ☐ Needs Reminders ☐ Poor ☐ Other/ List

48. **Mental Behaviors:**

☐ Delusions ☐ Obsessions ☐ Phobias ☐ Other/ List/ None

49. **Mental Health History:**

☐ Being Abused ☐ Being Abusive ☐ Substance Abuse ☐ Other/ List

50. Mood:

☐ Angry/ Anxiety ☐ Down/ Depressed ☐ Blunted ☐ Other/ None

51. **Mood Thoughts:**

☐ Happy ☐ Sad/ Depressed ☐ None ☐ Other/ List

52. **Muscular Issues:**

☐ Cramping/ Spasms ☐ Soreness/Sprains ☐ Weakness ☐ Other

53. **Numbness:**

☐ Location ☐ Hands/ Feet How Long Lasts ☐ Other

54. **Orientation:**

☐ Date ☐ Time ☐ Place ☐ Person

55. **Pain:**

☐ Acute ☐ Chronic ☐ Occasionally ☐ Other/ Never

56. **Pain Causes:**

☐ Movement ☐ Medicine ☐ Treatment ☐ Other/ No Pain

57. **Pain Description:**

☐ Aching ☐ Jabbing ☐ Sharp ☐ Other/ No Pain

58. **Pain Location:**

☐ Back ☐ Head(ache) Location ☐ Other/ No Pain

59. **Pain Management:**

☐ Change of Position ☐ Heat Pads ☐ Medication ☐ Other/ No Pain

60. **Perceptions:**

☐ Auditory ☐ Hallucinations ☐ Visual ☐ Other/ None

61. **Prosthesis:**

☐ Artificial Limb ☐ Brace ☐ Other/ None

62. **Psychiatric Treatment:**

☐ Anxiety/ OCD ☐ Bi-polar ☐ Depression/ PTSD ☐ Other/ None

63. **Religious Factors:**

☐ Daily ☐ Weekly ☐ Holidays ☐ Other/ None

64. **Risk:**

☐ Allergic ☐ Choking ☐ Fall ☐ Other

65. **Skeletal Issues:**

☐ Arthritis ☐ Injuries ☐ Scoliosis ☐ Other/ None

66. **Skin Condition:**

☐ Intact ☐ Redness ☐ Sore or Bed Sore ☐ Other/ None

67. **Skin Issues:**

☐ Eczema/ Itching ☐ Hives/ Rashes ☐ Psoriasis/ Moles ☐ Other/ None

68. **Sleeping Habits:**

☐ Insomnia ☐ Not enough ☐ Always sleepy ☐ Other/ Normal

69. **Smoking Habits:**

☐ Cigarettes/Cigars How many daily How many years ☐ Other/ None

70. **Speech:**

☐ No Speech ☐ Mild/ Severe ☐ Normal ☐ Other

71. **Speech Method:**

☐ Verbal ☐ Non-Verbal ☐ Sign/ Use Hands ☐ Other

72. **Suicidal Thoughts:**

☐ Attempted ☐ Considered ☐ Mentioned ☐ Other/ Never

73. **Teeth:**

☐ Dentures ☐ Partials ☐ Caps/Implants ☐ No teeth/Own Teeth

74. **Teeth/Tooth Issues:**

☐ Grinding ☐ Gum Problems ☐ Toothache ☐ Other ☐ None

75. **Transferring:**

☐ Self ☐ Assist ☐ Total Assist ☐ Other

76. **Urination:**

☐ Bloody ☐ Frequent ☐ Painful ☐ Other/ Normal

77. **Urine Color:**

☐ Light ☐ Dark ☐ Normal ☐ Other

78. **Vision:**

☐ Blind ☐ Contacts ☐ Glasses ☐ Other/ None

79. **Vision Issues:**

☐ Cataracts ☐ Glaucoma ☐ Blind ☐ Other/ None

80. **Wound(s):**

Location Degree Wound Care Other/ None ☐

81. **Other:** ☐ Yes

Client Signature:

Caregiver's Printed Name:

Caregiver's Signature:

Electronic Signature Disclaimer

Please ensure all information is correct before hitting Submit, as this is a Legal Document, and may be used in legal proceedings. Your signature is made with intent, and by signing your name electronically to this New Client Assessments, you are agreeing that your signature is the legal equivalent of your manual signature. If you want to opt out of the online New Client Assessments, or any other online form, please contact the office and paper forms will be sent to you.