

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 _____



CARE RESPONSE
Providing in-home health care
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Mental health _____

Current social/family support system _____

Functional Assessment

Medical problem list:

1 _____

2 _____

3 _____

4 _____

Current medications (name, dose and purpose):

1 _____

2 _____

3 _____

4 _____

Hospitalization/surgery history _____

Special diet _____

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 _____

Anxiety _____

Psychotic symptoms _____

Delusions _____

Hallucinations _____

Agitation _____

Behavioral disturbance _____

Financial Situation

Assets _____

Income _____

Long-term care insurance coverage _____

Legal information: Living will Health care surrogate POA Guardian _____

Entitlements (Social Security, pension) _____

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