

Carelink Health Care Services, LLC

Nursing Assessment

Page 1

Patient's Name _____

History Given by _____

Date _____

Current Diagnosis/Chief Complaints: _____

History/Developmental Milestones _____

Allergies: (environmental, drugs, food, etc.) _____

Immunizations: (Mark all that apply) ☐ NA-no immunizations

- Hepatitis: Type ____ (A/B/C) ____ / ____ (Mo/Yr) • Flu ____ / ____ (Mo/Yr)
- Tetanus/Diphtheria ____ / ____ (Mo/Yr) • Pneumonia ____ / ____ (Mo/Yr)
- Other: ____ / ____ (Mo/Yr)

Comments: _____

Vital Signs:

Temp. _____ Resp. _____ BP (designate position/s) _____

Pulse: Apical Rate _____ Radial Rate _____ Rhythm _____ Quality _____

Comments: _____

Life System Profile

5-WNL 4-Not Normal, but w/o help 3-Uses a device 2-With assistance 1-Device and help 0-Dependent

Activities of Daily Living (ADL)

- ____ Bathing
- ____ Dressing
- ____ Grooming
- ____ Toileting
- ____ Other: _____

Instrumental Activities of Daily Living (IDAL)

- ____ Telephone
- ____ Meal preparation
- ____ Housework
- ____ Laundry
- ____ Medicine management
- ____ Money management
- ____ Shopping
- ____ Manage appointments
- ____ Access resources
- ____ Transportation

Homebound Status (✓ appropriate blanks)

- ☐ Outdoors without assistance
- ☐ Outdoors with assistance
- ☐ Confined to house, not bed disabled
- ☐ Bed disabled

Comments: _____

Financial/Legal (✓ appropriate blank)

- ☐ Independent
- ☐ Needs assistance from _____
- ☐ Power of Attorney
- ☐ Living Will
- ☐ DNR discussed

Comments: _____

Habits: (✓ and describe)

- ☐ Alcohol
- ☐ Nicotine
- ☐ Sleep disorder
- ☐ Caffeine
- ☐ Street Drugs
- ☐ Other

Comments: _____

Physical Environment: (✓ appropriate blanks)

- ☐ All Adequate
- ☐ Inadequate space
- ☐ Stairs
- ☐ Interior safety hazards
- ☐ Structural hazards
- ☐ Electrical/fire hazards
- ☐ Transportation inadequate
- ☐ Private water supply/sewage disposal problem

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Comments: _____

Nursing Assessment

Page 2

Patient's Name _____

Date _____

Psycho-Social Profile: ☐ No problems (leave blank) ☐ S-subjective problem ☐ D-objectively assessed problem

☐ Hx of previous psych. illness	☐ Mood-depression/mania/liability	☐ Anxiety/agitation
☐ Memory loss-short term/long term	☐ Poor judgment	☐ Behavior problems
☐ Disorientation time/place/person	☐ Hallucinations/delusions	☐ Learning disabilities
☐ Communication barriers	☐ Emotional response to illness and care, body image	☐ Growth and development
☐ Interpersonal relationships	☐ Socialization	☐ Ethnicity

Comments: _____

Review of System/Physical Assessment: ☐ No problems (leave blank)

☐ S-subjective problem ☐ O-objectively assessed problem ☐ DNA- for did not assess

Head ☐ Dizziness ☐ Headache	☐ Vision loss (chose one) ☐ Minimal ☐ Moderate ☐ Severe ☐ Blind ☐ Not Determined	Eyes ☐ Glasses ☐ Blurred/double vision ☐ Change in vision (1 year) ☐ Glaucoma ☐ Cataracts ☐ PERRL	Ears ☐ Hearing loss (circle one) ☐ Minimal ☐ Moderate ☐ Severe ☐ Deaf	☐ Hearing aid ☐ Tinnitus
Mouth ☐ Gum problems ☐ Chewing problems ☐ Dentures upper - lower - both		Nose ☐ Epistaxis	Neck and Throat ☐ Hoarseness ☐ Difficulty Swallowing	

Comments: _____

Cardiovascular

☐ Palpitations ☐ Varicosities ☐ Chest pain ☐ Murmurs ☐ Pacemaker	☐ Dyspnea on exertion ☐ Claudication ☐ Fatigues easily ☐ Edema	☐ BR problems ☐ Paroxysmal nocturnal dyspnea ☐ Orthopnea; # pillows _____ ☐ Cyanosis
☐ WNL	☐ DNA	

Comments: _____

Respiratory

☐ Shortness of breath ☐ Shape and symmetry	☐ Wheezing ☐ Cough	☐ Sputum ☐ Breath sounds	☐ Oxygen ☐ Other
☐ WNL	☐ DNA		

Comments: _____

Gastrointestinal Track

☐ Indigestion ☐ Nausea, vomiting ☐ Ulcers	☐ Pain ☐ Hernias ☐ Diarrhea/constipation	☐ Rectal bleeding ☐ Hemorrhoids ☐ Gallbladder problems	☐ Jaundice ☐ Tenderness ☐ Ostomy
☐ WNL	☐ DNA		

Comments: _____

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Nursing Assessment Page 3

Patient's Name _____
Date _____

Nutritional Status

☐ Weight loss or gain last 3 months (amount _____) Height _____ Fluid intake amt/frequency _____
☐ Change in appetite Weight (actual) _____ (reported) _____

Diet _____ meals prepared by _____ times per day/wk
Comments: _____

Genitourinary Tract

☐ Frequency ☐ Nocturia ☐ Dysmenorrhea ☐ Gravida/Para
☐ Pain ☐ Urgency ☐ Lesions ☐ Date last PAP test
☐ Hematuria ☐ Vaginal discharge/bleeding ☐ Prostate disorder ☐ Contraception
☐ Incontinence ☐ Hx hysterectomy

☐ WNL ☐ DNA
Comments: _____

Breasts (for both male and female)

☐ Lumps ☐ Tenderness ☐ Discharge ☐ Pain ☐ Does Self-breast exam

☐ WNL ☐ DNA
Comments: _____

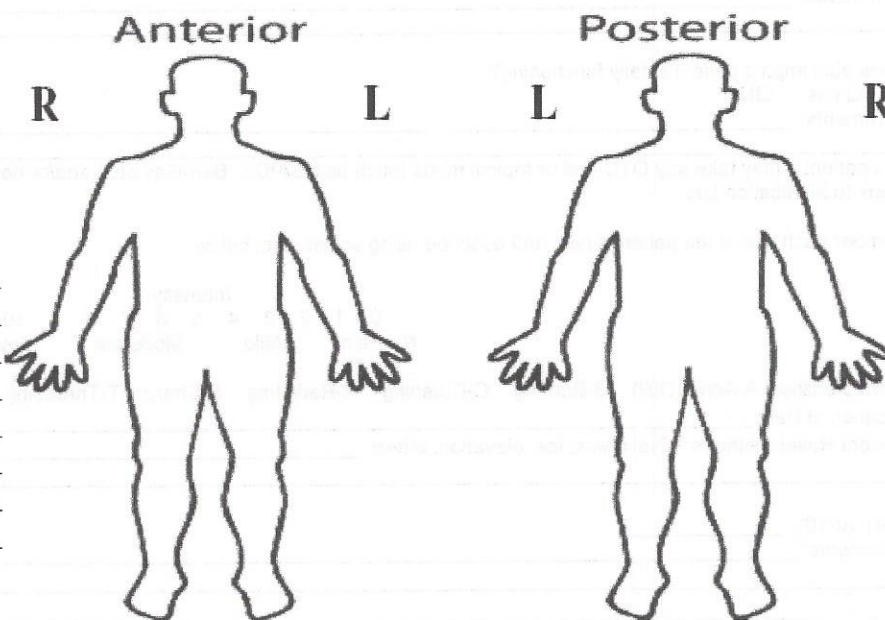
Integumentary

☐ Hair Changes
☐ Pruritus
☐ Color
☐ Turgor

Skin Condition (Record code # on body area.
Indicate size to right of numbered category.)

- 1 Lesions _____
- 2 Bruises _____
- 3 Masses _____
- 4 Incisions _____
- 5 Scars _____
- 6 Ulcers _____
- 7 Decubiti _____
- 8 Pressure areas _____

☐ WNL ☐ DNA
Comments: _____



Musculoskeletal, Neurological

☐ Stiffness ☐ Leg cramps ☐ Seizure ☐ Paralysis
☐ Swollen joints ☐ Numbness ☐ Tenderness ☐ Amputation
☐ Coordination ☐ Unequal grasp ☐ Deformities ☐ Tremor
☐ Joint pain ☐ Gait ☐ Temp changes ☐ Aphasia/inarticulate speech
☐ Weakness ☐ Syncope ☐ Balance ☐ Comatose

☐ WNL ☐ DNA
Comments: _____

Nurse Signature _____ Title: _____ Date _____

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Nursing Visit Record

Patients Name _____

Medical Record Number _____

Allergies: _____
 Medication change since last visit? ☐ No ☐ Yes, Specify _____
 Homebound? ☐ No ☐ Yes (If yes, reason) _____ Patient Lives - ☐ Alone, ☐ With Family, ☐ Non Relative

VITAL SIGNS	RESPIRATORY	SKIN		GU	CARDIOVASCULAR
☐ Temp: _____ ☐ Pulse: _____ ☐ Resp: _____ ☐ Wt: _____ ☐ BP: _____ _____ right _____ left ☐ Extremity Pulses ☐ Glucometer BS: _____ ☐ Universal Precautions Maintained	☐ No Deficit _____ ☐ Rale/Rhonchi _____ ☐ SOB _____ ☐ Cough _____ ☐ Sputum _____ ☐ O2 at _____ ☐ O2Sat _____ ☐ Other _____ Comments: _____	Edema Location _____ TR 1+ 2+ 3+ 4+ ☐ Non Pitting ☐ Pitting ☐ No Deficit ☐ Warm/Dry ☐ Cool/Clammy ☐ Turgor Adequate 1 st Wound Location _____ 2 nd Wound Location _____ aa _____ L _____ L _____ W _____ W _____ D _____ D _____ DRAINAGE Amt _____ Amt _____ Color _____ Color _____ Odor _____ Odor _____	☐ No Deficit ☐ Distention ☐ Retention ☐ Burning ☐ Frequency ☐ Foley cath ☐ Suprapubic ☐ Incontinence Size _____ F _____ ml Comments: _____	☐ No Deficit ☐ Chest Pain ☐ Heart Sounds ☐ Peripheral Pulses ☐ Dizziness ☐ Edema ☐ Neck Vein Distention ☐ Arrhythmia Comments: _____	

MUSCULOSKELETAL	NEUROLOGICAL	DIGESTIVE/NUTRITION	PAIN
☐ No Deficit ☐ Weakness ☐ Balance/Gait Abnormal ☐ Limited Mobility/ROM ☐ Pain ☐ Grip Strength right _____ left _____ ☐ Bed bound ☐ Chair bound ☐ Contracture ☐ Paralysis ☐ Assistive/Device Fall Precautions maintained	☐ No Deficit ☐ Oriented to Person / Place / Time ☐ Seizure/Tremors ☐ Pupillary Reaction Right/Left/Equal SENSORY ☐ Hearing Impaired ☐ Speech Impaired ☐ Visually Impaired ☐ Legally Blind	☐ No Deficit – Last BM _____ ☐ N/V ☐ Diarrhea ☐ Constipation ☐ Tube Feeding ☐ NPO Type/Amount _____ ☐ Placement ☐ Residual/Amt. _____ ☐ Bowel Sounds Present ☐ Abd. Girth ☐ Diet ☐ Meals Prepared & Administered Appropriately ☐ Past 24-Hour Diet Recall ☐ Adequate ☐ Inadequate	Frequency of Pain interfering with patient's activity or movement: ☐ 0 - Patient has none or pain doesn't interfere with activity or movement ☐ 1 - Less than daily ☐ 2 - Daily, but not constantly ☐ 3 - All of the time PAIN PROFILE Primary Site: _____ Intensity 0 1 2 3 4 5 6 7 8 9 10 low high Current pain management & effectiveness: _____ Pain Management Teaching to patient/family (document below) Patients pain goal: _____ Progress toward pain goal: _____

Reason for visit:	☐ LPN
	☐ Aide
	Present on this visit? Yes No
	Aide following care plan? Yes No
	Courteous and polite? Yes No
	Report changes in status? Yes No
	Patient satisfied with care? Yes No
Patient response to care:	Changes made to care plan? Yes No
	Additional instruction given? Yes No

Progress toward goals: _____
 Teaching Tools used/given: _____ ☐ Instructed ☐ Pt/Cg. Verbalized Understanding ☐ Pt/Cg. Return Demonstration
 Conference with: SN PT OT SLP MSS HHA (circle one) Name: _____ Regarding: _____
 Plan for Next Visit: _____

Patient Signature _____

Date _____

Nurse Signature & Title _____

Time In _____

Time Out _____

Date _____

☐ Nursing Supervisor Review _____

Supervisor Name _____

Supervisor Signature _____

Date _____

