Initial Skilled Client Assessment

TIME IN: **TIME OUT:**

Client Name:	**Sex:** ☐ Male ☐ Female	**Age:**	**DOB:**
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Life Partner			
Primary Language: ☐ English ☐ Other	**Language Barrier:** ☐ No ☐ Yes		
Religious or Cultural Factors Affecting Care: ☐ No ☐ Yes (Explain)			
Advanced Directives: ☐ Living Will ☐ Healthcare Surrogate – Name/Phone # ___ ☐ DNR – Copy visible or easily accessible at home? ☐ Yes ☐ No			

VITAL SIGNS		
Temperature		☐ Oral ☐ Rectal ☐ Auxiliary ☐ Tympanic
Pulse		☐ Apical ☐ Radial ☐ Weak ☐ Strong ☐ Bounding ☐ Regular ☐ Irregular
Respiration		☐ Regular ☐ Irregular ☐ Rapid ☐ Shallow ☐ Labored
Blood Pressure	___ / ___ ___ / ___	☐ Left arm ☐ Right arm ☐ Sitting ☐ Lying ☐ Standing ☐ Left arm ☐ Right arm ☐ Sitting ☐ Lying ☐ Standing
Height:		**Weight:**

Reason for Hospitalization and/or History of Chief Complaint (In client's own words): ___

___

___

___

CLIENT HISTORY/ASSESSMENT	
NEUROLOGICAL: ☐ No stated problem ☐ Memory loss ☐ Dementia ☐ Alzheimer's Disease ☐ Stroke ☐ Seizures ☐ Headache ☐ Dizziness Comments:___	**ONCOLOGY:** ☐ No stated problem ☐ Cancer Type: ___ Client currently receiving ☐ Chemotherapy ☐ Radiation Comments: ___
SENSORY: ☐ No stated problem ☐ Macular degeneration ☐ Glaucoma ☐ Cataracts ☐ Deaf Comments: ___	**Endocrine:** ☐ No stated problem ☐ Hyperthyroid ☐ Hypothyroid ☐ Hypoglycemia ☐ Diabetes Comments: ___
CARDIOPULMONARY: ☐ No stated problem ☐ Chest pain ☐ MI ☐ CABG ☐ AVR/MVR ☐ Angioplasty ☐ AICD ☐ Stent ☐ Irregular beats ☐ Pacemaker ☐ Hypertension ☐ Pneumonia ☐ Emphysema ☐ Asthma ☐ Bronchitis Comments: ___	**MUSCULOSKELETAL:** ☐ No stated problem ☐ Gout ☐ Arthritis ☐ Prosthesis: Describe: ___ ☐ Fracture(s): Describe: ___ Comments: ___
Gastrointestinal: ☐ No stated problem ☐ Bleeding ulcers ☐ Indigestion ☐ Difficulty swallowing ☐ Loss of appetite ☐ Hiatal hernia ☐ Hemorrhoids ☐ History of bariatric surgery Comments: ___	**INFECTIOUS DISEASE:** ☐ No stated problem ☐ TB ☐ Hepatitis ☐ Immunosuppressed ☐ MRSA ☐ C-Diff **Immunizations**: Flu ☐ No ☐ Yes Date: ___ Pneumococcal ☐ No ☐ Yes Date: ___ Comments: ___
Genitourinary: ☐ No stated problem ☐ Prostate ☐Dialysis ☐ AV access: ☐ Right ☐ Left Comments: ___	**PSYCHOLOGICAL:** ☐ No stated problem ☐ Depression ☐ History of chemical/ETOH dependency ☐ Phobia Type: ___ Comments: ___

FUNCTIONAL SCREEN

Has client had a recent change in functional and/or gait status due to injury, surgery, or illness? ☐ No ☐ Yes (Explain) ___________________________________

____

Activity	Independent	Mechanical Help	Human Help		Dependent	Who Provides Assistance		
			Assist	Set-Up		HH Agency	Family	Hired Help
Bathing/Showering								
Dressing/Undressing								
Grooming:								
Hair								
Oral Care								
Shaving								
Toileting								
Transfers								
Ambulation								
Bed mobility								
Stair climbing								
Medications								
Preparing meals								
Eating / Feeding								
Errands / Dr. Appts.								
Transportation								
Use of telephone								
Light housekeeping								

NUTRITION

Appetite: ☐ Good ☐ Fair ☐ Poor

Diet: ☐ Regular ☐ Low salt ☐ Diabetic ☐ Other ____________________

Difficulty with: ☐ Chewing ☐ Swallowing ☐ Thickened liquids needed

Nutritional Supplements (specify):____________________________________

☐ PEG Tube ☐ NG Tube

Enteral Nutrition via: ☐ Gravity ☐ Pump

Type of formula: ____

Rate: ____________________ mL/Hr

Comments: ____

SENSORY ☐ No problem

☐ **Dentures:** ☐ Upper ☐ Lower ☐ Both

☐ **Glasses** ☐ **Contacts**

☐ **Loss of sight**: ☐ Right eye ☐ Left eye

☐ **Loss of hearing**: ☐ Right ear ☐ Left ear

☐ Hearing aid(s): ☐ Right ☐ Left

Altered sense of : ☐ Taste ☐ Smell ☐ Touch

Comments: ____

GASTROINTESTINAL ☐ No problem

☐ **Colostomy**

☐ **Illeostomy**

☐ **Constipation:** Last BM: ____

☐ **Diarrhea:** #stools / day ____

☐ **Nausea / Vomiting**

☐ **Other**: ____

Comments: ____

GASTROURINARY ☐ No problem

☐ **Urgency**

☐ **Voiding frequently**: __________________ times / day

☐ **Incontinence**

☐ **Nocturia**

☐ **Pain / Burning / Difficulty with urination**

☐ **Catheter**

☐ **Other:** _________________________

Comments: ____

RESPIRATORY ☐ No problem

☐ **Shortness of breath**: ☐ On exertion ☐ At rest

☐ **Cough:** ☐ Dry ☐ Wet **Color of sputum:** __________________________

☐ **Oxygen:** __________________L/min ☐ Nasal ☐ Mask

☐ PRN ☐ Continuous

☐ **CPAP:** ☐ NA Settings_____________

☐ **BiPAP:** ☐ NA Settings______________

☐ **Other**: ____

Comments: ____

CARDIOVASCULAR ☐ No problem

☐ **Chest pain**

☐ **Edema: Location**____

____

____

☐ **Other:** ____

Comments:____

PSYCHO/NEUROLOGIC ☐ No problem	MUSCULOSKELETAL ☐ No problem
☐ **Alert** ☐ **Oriented:** ☐ Person ☐ Place ☐ Time ☐ **Forgetful** ☐ **Vertigo** (*Dizziness*) ☐ **Hallucinations** ☐ **Agitated** ☐ **Anxious / Nervousness** ☐ **Drowsiness** ☐ **Sleep disturbances** ☐ **Seizures** ☐ **Tremors** ☐ **Other:** ____________________ Comments: ____________________	☐ **Joint / muscle pain** ☐ **Muscle cramping/ twitching** ☐ **Stiffness** ☐ **Weakness**: Location: ____________________ ____________________ ☐ **Requires assistance** ☐ **Unsteady gait** ☐ **Shuffling gate** ☐ **Other**: ____________________ Comments: ____________________

FALL RISK ASSESSMENT				
Client Assessment	**Check If Factor Applicable**	**Check If Intervention Done**	**Intervention***	
				Other Interventions
Fall within last 12 months			**Evaluate cause**	
Muscle weakness			**Request assistance**	
Unsteady gait			**Request assistance**	
Balance deficit / Dizziness			**Change position slowly**	
Use of assistive device			**Appropriate use of device**	
Connected to tubing (O^2 or IV)			**Awareness**	
Visual deficit			**Extra lighting**	
Impaired ADL			**Provide assistance**	
Urinary incontinence / urgency			**Commode**	
Confusion			**Review medication**	
Impaired memory / judgment			**Written instructions**	
Unable to follow directions			**Educate caregiver**	
Non-compliant with safety issue(s)			**Advise about results**	
Seizure disorder			**Precautions education**	
More than 4 medications			**Review medication**	
Use of psychotropic medication			**Review medication**	
Use of antiarrhythmic / diuretic			**Review medication**	
Environmental Assessment				
Poor lighting			**Extra light**	
Loose rugs / slippery floor			**Remove rugs**	
Cords in pathway			**Put cord out of pathway**	
Walkways cluttered			**Clear walkways**	
Toilet sits low			**Elevated toilet seat**	
Phone, etc. not within easy reach			**Put items within reach**	
Bathroom			**Grab bar(s) present**	

***Interventions based on client's condition. If 6 or more factors applicable, client is high fall risk.**

ENVIRONMENTAL / HOME SAFETY	
Environmental Problems? ☐ **Yes** ☐ **No** ☐ Air/Heat ☐ Electrical ☐ Stairs ☐ Infestation ☐ Water ☐ Sanitation Working Smoke Detector? ☐ Yes ☐ No Recommendations: ____________________	**Use of Medical Equipment?** ☐ **Yes** ☐ **No** ☐ Hospital bed ☐ Wheelchair ☐ Walker ☐ Cane ☐ Brace ☐ Prosthesis ☐ Splints ☐ Shower chair ☐ Bedside commode ☐ Hoyer lift ☐ Crutches ☐ Trapeze ☐ Oxygen ☐ Nebulizer ☐ Suction ☐ Other: __________ Recommendations: ____________________
Living Situation Others in the home: ☐ Full time ☐ Part time ☐ Alone Others in home willing to assist with ADLs, home making, etc.? ☐ Yes ☐ No **Comments**: ____________________ **Family Concerns/Risks**: ____________________	**Community Resources** Is the patient currently receiving any assistance from the community? ☐ Yes ☐ No If yes, please explain: ____________________

OXYGEN RISK ASSESSMENT ☐ Not Applicable			INTERVENTION	DATE
"No Smoking" or "Oxygen In Use" sign is visible in the home and on front door.	☐ Yes	☐ No	☐ Instructed to obtain/post sign	
Does client smoke?	☐ Yes	☐ No	☐ Instructed not to smoke with oxygen on	
Does a family member smoke?	☐ Yes	☐ No	☐ Instructed not to smoke with oxygen on	
Does the client use matches or lighter?	☐ Yes	☐ No	☐ Instructed not to smoke with oxygen on	
Does client cook with gas stove?	☐ Yes	☐ No	☐ Instructed not to smoke with oxygen on	
Does client use a wood burning stove or fireplace?	☐ Yes	☐ No	☐ Instructed not to smoke with oxygen on	
Does the client have lighted candles?	☐ Yes	☐ No	☐ Instructed not to smoke with oxygen on	
Do the client or family members have an evacuation plan?	☐ Yes	☐ No	☐ Reviewed evacuation plan	

MEDICATION

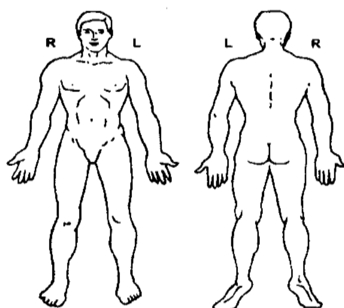
*Client takes medication regularly ☐ Yes ☐ No ☐ Self-administer ☐ Needs assist ☐ Needs reminder

Allergies: ____

*COMPLETE MEDICATION LIST IF PROVIDING SKILLED NURSING OR WORKER ASSISTS OR REMINDERS

INTEGUMENTARY ☐ No problem

☐ Itching ☐ Rashes ☐ Bruises ☐ Sores ☐ Dryness ☐ Skin tears ☐ Draining wounds ☐ Pressure ulcers



☐ No Problem Visualized

R L

Indicate Codes on Figure
1. Wound
2. Edema
3. Implanted Ports
4. Pacemaker
5. Bruise
6. Rash
7. Skin Tear
8. Pressure Ulcer
   - ☐ Non-Blanchable erythema
   - ☐ Partial Thickness
   - ☐ Full Thickness
   - ☐ W/O unable to determine covered č necrosis/slough
9. Reddened Area
10. Ostomy
11. Scar Ports
12. Abrasion
13. Laceration
14. Burn
15. Other______________
    ____
    ____

MARK LOCATION

Describe Skin Abnormalities:

____

____

____

____

____

____

____

Treatment Provided:

____

____

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____

PAIN ASSESSMENT
Is the client experiencing pain now? ☐Yes ☐ No If yes, answers questions below based on client's condition
Client's pain goal: ☐ No pain ☐ Partial relied (target score) _______________ ☐ Other ____

PAIN SCALES

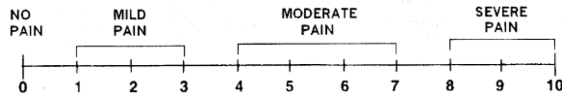
PAIN ASSESSMENT IN ADVANCED DEMENTIA SCALE (PAINAD)

Instructions: Observe the client for five (5) minutes before scoring his/her behaviors. Score the behaviors according to the chart below. The client can be observed under different conditions (e.g., at rest, during a pleasant activity, during care giving, after the administration of pain medication).

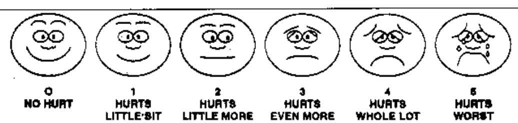
Scoring: The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3 = mild pain; 4-6 = moderate pain; 7-10 = severe pain

Behavior	0	1	2	Score
Breathing independent of vocalization	• **Normal**	• **Occasional labored breathing** • **Short period of hyperventilation**	• **Noisy labored breathing** • **Long period of hyperventilation** • **Cheyne-Stokes respirations**	
Negative vocalization	• **None**	• **Occasional moan or groan** • **Low-level speech with a negative or disapproving quality**	• **Repeated troubled calling out** • **Loud moaning or groaning** • **Crying**	
Facial expression	• **Smiling or inexpressive**	• **Sad** • **Frightened** • **Frown**	• **Facial grimacing**	
Body language	• **Relaxed**	• **Tense** • **Distressed pacing** • **Fidgeting**	• **Rigid** • **Fists clenched** • **Knees pulled up** • **Pulling or pushing away** • **Striking out**	
Consolability	• **No need to console**	• **Distracted or reassured by voice or touch**	• **Unable to console, distract, or reassure**	
			Total Score	

PAIN INTENSITY SCALE



WONG-BAKER FACES SCALE



Location of pain: ____

Observation of pain site: ____

Present management of pain: ____

Quality	☐ Ache ☐ Burn ☐ Throb ☐ Sharp ☐ Dull ☐ Stabbing ☐ Other ______________________________
Onset	☐ Sudden ☐ Gradual ☐ Other ____
Symptoms associated with pain	☐ Nausea ☐ Headache ☐ Dizziness ☐ Weakness ☐ Drowsiness ☐ Perspiration ☐ Unable to sleep ☐ Loss of appetite ☐ Affects ADLs ☐ Other ____________________________________
Duration	☐ Continuous ☐ Intermittent How long does it last? _________________ ☐ Other __________________
Aggravating factors	☐ Rest ☐ Activity ☐ Heat ☐ Cold ☐ Medication ☐ Other ______________________________
Alleviating factors	☐ Rest ☐ Activity ☐ Heat ☐ Cold ☐ Medication ☐ Other ______________________________

Previous major illnesses and/or injuries that are not related to current diagnosis/claim: ____

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____

Client's expectations for services: ____

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Return to work goals: ____

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Suggestions/plan of care to reach goals: ____

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____

Instructions provided/patient education: ____

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Others involved in client's care: ____

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____

☐ **Home Health Agency:** ____

☐ **Hospice:** ____

☐ **Other:** ____

Support system (Name) ___________________________________ **(Relationship)** _______________ **(Phone)** ______________

Emergency contact (Name) ________________________________ **(Relationship)** _______________ **(Phone)** ______________

____________________________________	____________________________________	______________
Nurse Signature and Title	**Print Name**	**Date**
____________________________________	____________________________________	______________
Client or Representative Signature	**Relationship**	**Date**