Unique Health Care LLC
RN Intake Assessment/Evaluation

Client Name:_____DOB:_____

Admission Date: _____Today Date: _____Record #_____

Vitals
Temperature:_____
Pulse:_____
Respiration:_____
Blood Pressure:_____
Weight:_____
Height:_____

Assistive Devices Used (check all that apply)
☐ Glasses ☐ Electric Cart/Scooter
☐ Hearing Aid ☐ Walker
☐ Dentures ☐ Oxygen
☐ Cane ☐ Assistive Dressing Devices
☐ Wheelchair ☐ Other
☐ Other: _____

Allergies: Latex ☐ **Yes** ☐ **No** **Other: _____**

Diagnosis:
Primary Active:_____

Secondary Active:_____

Vaccination Status:
☐ **Pneumonia vaccination received** ☐ **Yes** ☐ **No** **Date:_____**
☐ **Flu vaccination received:** ☐ **Yes** ☐ **No** **Date:_____**
TB Status, If known:_____
Special diet:_____

Sensory Loss & Communication Problems:
☐ Vision ☐ Glaucoma ☐ Cataracts ☐ Macular Degeneration
Comments:_____
Hearing:_____
Smell:_____
Communication Problems:_____

ADLs	Independent	Needs minor assist	Needs supervision/ Oversight	Needs Assistance	Totally Independent	Comments
Dressing						
Toileting						
Bathing						
Hair Care						
Oral Hygiene						
Shaving						
Eating						
Transferring						
Mobility						
Self-Preservation						

IDALs	Independent	Needs minor assist	Needs supervision/ oversight	Needs assistance	Total Dependent	Comments
Telephone						
Finances						
Shopping						
Laundry						
Housekeeping						
Food Prep						
Appts.						
Transportation						

Skin Integrity:

☐ **Rash** ☐ **Pale** ☐ **Open Sores** ☐ **Itching** ☐ **Moist**

☐ **Cellulitis** ☐ **Cool** ☐ **Flushed**

☐ **Other:**_____

Endocrine:

☐ **Thyroid**

☐ **Diabetes** **Treatment:**_____

(Assistance needed with blood glucose monitoring?_____

☐ **Hyperglycemia**

☐ **Hypoglycemia**

☐ **Other:**_____

Neurological:

☐ **Stroke** ☐ **Paralysis** ☐ **Dizziness**

☐ **Parkinson's** ☐ **TIA's** ☐ **Seizures**

☐ **Headaches**

☐ **Other:**_____

Gastrointestinal:

☐ **Heartburn** ☐ **Gastric reflux** ☐ **Nausea/Vomiting**

☐ **Constipation** ☐ **Diarrhea** ☐ **Bowel Incontinence**

☐ **Other:**_____

Cardiovascular/Circulatory:

☐ **Heart Disease** **Treatment:**_____

☐ **High Blood Pressure** ☐ **Chest Pain** ☐ **Heart Attack**

☐ **Pacemaker** ☐ **Edema – Location:**_____

☐ **Other:**_____

Genitourinary:

☐ **Urinary incontinence** ☐ **Partial** ☐ **Total**

How Managed: _____

Respiratory:

☐ **Shortness of Breath** ☐ **Cough** ☐ **Bronchitis** ☐ **Pneumonia**

☐ **Emphysema** ☐ **Smoker/History of Smoking** ☐ **Asthma**

Treatment_____

Musculoskeletal

☐ **Fractures** ☐ **Arthritis** ☐ **Osteoporosis**
☐ **Joint Replacement:**_____
☐ **Pain** **Location:**_____
Cause:_____
Intensity:_____
Relieved by:_____

Psychological/Cognitive:
☐ **Alert**
☐ **Orient to:** ☐ **Person** ☐ **Place** ☐ **Time**
☐ **Forgetful** ☐ **Confused** ☐ **Wanders**
☐ **Sad/Depressed** ☐ **Anxiety** ☐ **Memory Loss**
☐ **Paranoid** ☐ **Impaired Decision-making**
☐ **Mental illness or cognitive impairment diagnosis**
☐ **Behavior issues (verbal or physical aggression**

☐ **Other**_____

Other Issues or Problems:
☐ **Afraid of falling** ☐ **Has fallen in past year** _____**# of falls**
☐ **Sleep patterns** ☐ **Frequent Hospitalizations**
☐ **Cancer:**_____
Treatement_____

☐ **Alcohol/controlled substance use How often/how much:**_____

☐ **Other**_____
_____
_____

Family Support:_____
_____
_____

Client Strengths:_____
_____
_____
_____

Other Observartions/Notes:_____
_____
_____

Over-the-Counter Herbal & Prescription Medications (if possible, do a brown bag)

Medication	Dose	Frequency	Route	Prescriber	Reason Use	Pharmacy

☐ **See Medication Management Plan/MAR for completed Medication Assessment**

_____

Evaluation Completed by: (Name/Title)

_____

RN Signature **Date**

Client/Client Representative Signature **Date**