- ☐ INITIAL
- ☐ ANNUAL
- ☐ PERIODIC

Generations Senior Living
Health Assessment

Resident Name: ______________________________ DOB: ____________________

Medical Diagnoses (include developmental diagnoses and/or intellectual disabilities if applicable):

Psychological History:

Health History:

History / Risk of falls? ☐ Yes ☐ No Explain ______________________________

____

History of wandering? ☐ Yes ☐ No Explain ______________________________

____

VITAL SIGNS	Temp	Pulse	Resp. (Resting)	Blood Pressure	Height ft____ in____	Current Weight ____________ History of Weight Changes ____________

EARS/HEARING

☐ Good ☐ Partially Deaf ☐ Completely Deaf

☐ Limited (Must speak loudly) ☐ Aid: R ____ L _____

EYES/VISION

☐ Good ☐ Adequate ☐ Limited Vision ☐ Blind

☐ Uses Aid ☐ Unable to Read ☐ Glaucoma: Y ____ N____

☐ Cataract Surgery Dates: R _______ L________

TEETH ______________________________

SKIN ______________________________

HEART ______________________________

ABDOMEN ______________________________

EXTREMITIES______________________________

NOSE/THROAT ______________________________

SCARS ______________________________

LUNGS ______________________________

HERNIA ______________________________

PHYSICAL IMPAIRMENTS ______________________________

COGNITIVE FUNCTION: ☐ Normal ☐ Impaired, If Impaired: ☐ Mild ☐ Moderate ☐ Severe

MEDICATIONS – PRESCRIPTION: Attach list of all medications, including route and dosage
NOTE: PRN medications must include indications/instructions

MEDICATION ALLERGIES: ______________________________

MEDICATION ADMINISTRATION (please indicate): ☐ Self-Administered ☐ Requires Administration by Licensed Professional

EVALUATION TO TREAT: ☐ PT ☐ OT ☐ SPEECH ☐ SKILLED NURSING ☐ HOSPICE

IMMUNIZATION HISTORY: Please indicate if the individual has the following vaccinations:

Pneumovax	☐ Yes	☐ No	Date of vaccination: ____________
Influenza (Flu)	☐ Yes	☐ No	Date of vaccination: ____________
Tetanus	☐ Yes	☐ No	Date of vaccination: ____________
Shingles	☐ Yes	☐ No	Date of vaccination: ____________

FUNCTIONAL ASSESSMENT

Resident Name ______________________

ADL Assessment	**Assistance Required**			**Instrumental Activities of Daily Living**			
	Independent	Needs Supervision	Needs Assistance		Independent	Needs Supervision	Needs Assistance
Ambulation	☐	☐	☐	Using Telephone	☐	☐	☐
Continence	☐	☐	☐	Preparing Own Meals	☐	☐	☐
Transfer	☐	☐	☐	Housework	☐	☐	☐
Dressing	☐	☐	☐	Shopping	☐	☐	☐
Feeding	☐	☐	☐	Laundering	☐	☐	☐
Bathing	☐	☐	☐	Heavy Chores	☐	☐	☐
Sleeping Patterns				Acquire/Use Transportation	☐	☐	☐
Bathing Patterns				Manage Financial/Legal Affairs	☐	☐	☐

Hobbies / Usual Activities______________________
Socialization Preferences ______________________
Religious Preferences ______________________

TYPE OF CARE OR SERVICE INDIVIDUAL REQUIRES BASED ON THE FUNCTIONAL ASSESSMENT:

☐ Independent ☐ Minimal Assistance ☐ Moderate Assistance ☐ Maximum Assistance

DIET REQUIREMENTS

☐ Regular ☐ Reduced or No Simple Sugar Food Regimens ☐ No Added Salt Food Regimens
☐ Other ______________________ Please Explain______________________

***FOOD ALLERGIES**
____
____
____

Adaptive Equipment? ☐ Yes ☐ No Type______________________
Food Intolerances ______________________
Food Preferences ______________________
Assistance During Meals? ☐ Yes ☐ No Type______________________

ADMISSION TUBERCULOSIS SCREENING

PHYSICIAN: By checking either option and signing the Health Assessment, you will be giving the facility an order to complete Mantoux TB skin testing for this resident.

Date of last known TB screening ___/___/___

☐ **2 STEP** 5 T.U. PPD intradermally x 1, if non-significant, repeat dose on 7th day

☐ **1 STEP** 5 T.U. PPD intradermally x 1. Record of a single or two-step Mantoux TB skin test ***within one year*** is required if checking this option.

☐ **NO** Individual is a known reactor. Date of chest X-ray within past 6 months ___/___/___

DOES THE INDIVIDUAL HAVE APPARENT SIGNS AND SYMPTOMS OF INFECTIOUS DISEASE WHICH IS LIKELY TO BE TRANSMITTED TO OTHER RESIDENTS OR STAFF? ☐ Yes ☐ No

DOES THE INDIVIDUAL REQUIRE 24 HOUR NURSING SUPERVISION? ☐ Yes ☐ No
Explain______________________

DOES THE INDIVIDUAL REQUIRE SKILLED NURSING SERVICES? ☐ Yes ☐ No
If YES: Type, Amount, Frequency, Duration ______________________
(Skilled nursing services other than administration of medication, supervision of special diets and application of dressings. These may only be provided on a part-time intermittent basis. Less than 8 hours/day, less than 40 hours/week for no more than 120 days in any 12 month period)

I AM AUTHORIZING THE CONTINUED REFILL OF ALL THE CURRENTLY PRESCRIBED MEDICATIONS UNTIL THIS RESIDENT'S NEXT SCHEDULED APPOINTMENT.

PHYSICIAN SIGNATURE ______________________ DATE ______________

EXAMINER NAME	
ADDRESS	
PHONE	

PLEASE RETURN COMPLETED FORM TO:
Generations Senior Living of Berea
4 BEREA COMMONS
BEREA, OH 44017
Phone: 440-243-9050 **Fax: 440-243-9178**