

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 _____



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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 Senior Planning Services for more information on how to use this information and what care needs are required based on the information gathered.