# New Horizons Adult Day Center
# Assessment

Admission ☐ 30-Day ☐ Annual ☐ Significant Change ☐

## GENERAL

Participant Name:

Address: City/State: Zip:

Home Phone: Cell Phone:

Living Arrangements: Home with family ☐ Independent Living ☐ Assisted Living ☐ SNF ☐
Other: Please Specify:

Birthdate: Gender: M ☐ F ☐ Marital Status: M ☐ W ☐ D ☐ S ☐

Age: Race: SSN#: County:

Medicaid #: Medicare #: VA #:

Level/Care: Other Ins. Policy #:

## RESPONSIBLE PARTY/CAREGIVER

Name: Relationship:

Address: City/State: Zip:

Phone: (h) (w) (c)

## OTHER CONTACTS/EMERGENCY

Name: Relationship:

Address: City/State: Zip:

Phone: (h) (w) (c)

Name: Relationship:

Address: City/State: Zip:

Phone: (h) (w) (c)

FINANCIAL POWER OF ATTORNEY HEALTH CARE POWER OF ATTORNEY OR GUARDIAN

Name: Relationship:

Address: City/State: Zip:

Phone: (h) (w) (c)

DPA: Name:

Phone: (h) (w) (c)

PAYMENT SOURCES

Waiver: Y ☐ N ☐ Type: BI ☐ EW ☐ HD ☐ ID ☐ AH ☐ ID#:

SSN#: (For Waiver/VA Billing)

VA: Y ☐ N ☐ Private: Y ☐ N ☐ Bill to:

Scholarship: Y ☐ N ☐ Iowa Family Caregivers: Y ☐ N ☐ SLP: Y ☐ N ☐

CASE MANAGEMENT

Case Manager: Y ☐ N ☐

Name: Phone:

County: Group: Fax:

MEDICAL PROVIDERS

Primary Physician: Phone:

Address: City: State: Zip:

Fax: Other:

Other Physician: Phone:

Address: City: State: Zip:

Fax: Other:

Preferred Hospital:

## DIAGNOSIS / DISABILITY DESCRIPTION / HOSPITALIZATION

*Please check all that apply*

| Diagnosis | X | Date of Onset | Describe |
|---|---|---|---|
| Recent Hospitalization | ☐ | | |
| Alzheimer's Disease | ☐ | | |
| Dementia | ☐ | | |
| Stroke | ☐ | | |
| TBI/BI | ☐ | | |
| Anoxia/Hypoxia | ☐ | | |
| Fall | ☐ | | |
| Tumor | ☐ | | |
| Aneurysm | ☐ | | |
| Motor Vehicle Accident | ☐ | | |
| Seizures | ☐ | | If yes, see below |
| Spinal Cord Injury | ☐ | | |
| MS | ☐ | | |
| Parkinson's Disease | ☐ | | |
| Hearing Impairment | ☐ | | |
| Vision Impairment | ☐ | | |
| Drug Allergies | ☐ | | |
| Environmental Allergies | ☐ | | |
| Food Allergies | ☐ | | |
| Other | ☐ | | |

| Seizure Type—In last 12 months | Frequency | Date of Last Seizure |
|---|---|---|
| Simple partial (simple motor movements affected, no loss of awareness) | | |
| Complex partial (loss of awareness) | | |
| Generalized/Absence (Petit Mal) | | |
| Generalized/Tonic/Clonic (Grand Mal) | | |
| Not sure of type | | |

How frequently have seizures involved loss of awareness and/or consciousness?

- ☐ None
- ☐ Less than once a month
- ☐ About once a month
- ☐ About once a week
- ☐ Several times a week
- ☐ Once a day or more

MEDICATION INFORMATION

Name:

DOB:

Medicaid #:

Medication Administered by: Nurse/Staff ☐ Self ☐ Staff Reminder: Yes ☐ No ☐

| Reviewed | D/C | Medication | Dosage | Frequency/Time | Physician |
|---|---|---|---|---|---|

Do you require direct care staff trained in special health care procedures (e.g. ostomy care, positioning adaptive devices)? Yes ☐ No ☐ If yes, please explain:

## SELF-CARE AND DAILY LIVING SKILLS

Indicate how independently you perform each activity by assigning 1 – 5 for each task:

1 = Independent – complete without assistance or cues
2 = Supervision – requires verbal prompting only
3 = Assistance – requires hands on help / prompts for safety
4 = Dependent – requires total assistance

| **Activity** | **1** | **2** | **3** | **4** |
|---|---|---|---|---|
| Toileting | ☐ | ☐ | ☐ | ☐ |
| Showering or bathing | ☐ | ☐ | ☐ | ☐ |
| Brushing teeth | ☐ | ☐ | ☐ | ☐ |
| Combing hair | ☐ | ☐ | ☐ | ☐ |
| Selecting appropriate clothes for weather | ☐ | ☐ | ☐ | ☐ |
| Putting on clothes | ☐ | ☐ | ☐ | ☐ |
| Undressing Self | ☐ | ☐ | ☐ | ☐ |
| Chewing and Swallowing Food | ☐ | ☐ | ☐ | ☐ |
| Feeding self | | | | |
| ☐ Regular utensils ☐ adaptive utensils ☐ Finger foods | ☐ | ☐ | ☐ | ☐ |
| Drinking from cups/glass | ☐ | ☐ | ☐ | ☐ |

Checkmark where you can complete the following:

☐ Make bed ☐ Clean Room ☐ Laundry task ☐ Use telephone ☐ Shop for meals
☐ Prepare food that does not require cooking ☐ Use stove or microwave
☐ Cross street in neighborhood ☐ Use public transportation
☐ Manage own money ☐ Plan leisure activities

## AMBULATION

☐ Walks independently ☐ Walks with assistance ☐ Does not walk

Uses the following assistive device:

☐ Cane ☐ Frame / 4-wheel Walker ☐ Assist of 1 ☐ Wheelchair ☐ Electric Wheelchair

## TRANSFERS

☐ Independent ☐ Needs supervision ☐ Assist of 1 ☐ Assist of 2/other equipment

## ELIMINATION

Continent: Yes ☐ No ☐

Incontinent: Yes ☐ No ☐ Bowel ☐ Bladder ☐ Both ☐ Day ☐ Night ☐ Both ☐

Total incontinence protectors worn: ☐ Catheter ☐ Bladder Program ☐ Bowel Program

If program, please explain:

## NUTRITION

Height: Weight:

Accepts a general diet? Yes ☐ No ☐ Current diet order:

Swallowing within normal limits? Yes ☐ No ☐
If no, check those which apply:
☐ Pureed ☐ G-tube ☐ Swallowing study done (Date: )
☐ Mechanical Soft ☐ G-tube supplement with meals ☐ G-tube for water flush only
☐ Thickened Liquids ☐ Nectar-thick ☐ Honey-thick ☐ Pudding-thick
☐ Aspirates ☐ Solids ☐ Liquids ☐ Thin liquids only

Diet restrictions:

## COGNITIVE AND COMMUNICATION

☐ Vocalizing
☐ Signing
☐ Gestures
☐ Utilization of facial expressions
☐ Utilization of communication board
☐ Other

☐ Unable to express needs appropriately or consistently despite prompting
☐ Engages with others or responds to reassurance and redirection
☐ Sometimes inconsolable
☐ Reads

Is the individual currently using any memory aids? Yes ☐ No ☐
If yes, what? ☐ Calendar ☐ Daily Planner ☐ Reminder Notes ☐ Other:

Comments:

## TRANSPORTATION

| **Can you complete the following?** | **Yes** | **No** | **Comments** |
|---|---|---|---|
| Drive a car? | ☐ | ☐ | |
| Take a cab independently? | ☐ | ☐ | |
| Ride a paratransit bus? | ☐ | ☐ | |
| Ride a facility bus? | ☐ | ☐ | |
| Self-transfer to a vehicle? | ☐ | ☐ | |
| Recognize a destination | ☐ | ☐ | |

Comments:

## SOCIAL / EMOTIONAL / BEHAVIORAL ISSUES

Describe any behaviors that cause difficulty interacting with others or which limit your ability to participate in vocational/educational/recreational programming.

| **Do you have this?** | **No** | **Yes** | **If yes, please describe:** |
|---|---|---|---|
| Agitation | ☐ | ☐ | |
| Impulsivity | ☐ | ☐ | |
| Paranoia | ☐ | ☐ | |
| Depression | ☐ | ☐ | |
| Social immaturity | ☐ | ☐ | |
| Dependency | ☐ | ☐ | |
| Egocentrism | ☐ | ☐ | |
| Liability | ☐ | ☐ | |
| Obsessional disorder | ☐ | ☐ | |
| Lack of initiative | ☐ | ☐ | |
| Social isolation | ☐ | ☐ | |
| Excessive talking | ☐ | ☐ | |
| Increased sexual interest | ☐ | ☐ | |
| Disorganization | ☐ | ☐ | |
| Memory deficit | ☐ | ☐ | |
| Perceptual problems | ☐ | ☐ | |
| Language deficits | ☐ | ☐ | |
| Physical Limitations | ☐ | ☐ | |
| New Learning Problem | ☐ | ☐ | |
| Lag in response time | ☐ | ☐ | |
| Reduce auditory compensation | ☐ | ☐ | |
| Problem solving deficit | ☐ | ☐ | |
| Cognitive inflexibility | ☐ | ☐ | |
| Visual limitations | ☐ | ☐ | |

Describe a typical day:

SOCIAL HISTORY AND RECREATIONAL INTERESTS

**Personality:** ☐ Outgoing ☐ Loner ☐ Sedentary ☐ Involved ☐ Spectator ☐ Leader ☐ Sociable

**Religion**

Denomination: Church: Phone:

**Childhood**

Where did you grow up?

How many siblings did you have?

What did your parents do?

Name/City of schools attended: Highest grade completed:

**Adulthood**

Did you serve in the military (if yes, which branch)?

When did you get married?

Previous Employment (how long? Where?):

Do you have children? What are their names?

Do you have any grand-children? How many?

Do you have any great-grandchildren? How many?

| **Does the person like:** | **Yes** | **No** |
|---|---|---|
| To be with others | ☐ | ☐ |
| To be alone | ☐ | ☐ |
| Small groups | ☐ | ☐ |
| Large groups | ☐ | ☐ |
| Being touched | ☐ | ☐ |
| Touching | ☐ | ☐ |
| Helping others | ☐ | ☐ |
| Being helped by others | ☐ | ☐ |

| **Is this person?** | **Yes** | **No** |
|---|---|---|
| Impulsive | ☐ | ☐ |
| Easily frustrated | ☐ | ☐ |
| Competitive | ☐ | ☐ |
| Unassertive | ☐ | ☐ |
| Aggressive | ☐ | ☐ |
| A perfectionist | ☐ | ☐ |

| **Does this person?** | **Yes** | **No** |
|---|---|---|
| Panic easily | ☐ | ☐ |
| Become angry | ☐ | ☐ |
| Think before acting | ☐ | ☐ |
| Give up easily | ☐ | ☐ |
| Have patience | ☐ | ☐ |
| Use good judgment | ☐ | ☐ |

**Interests**

| **Activities** | **Yes** | **No** | **Comments/Likes** |
|---|---|---|---|
| Movies/ T.V. | ☐ | ☐ | |
| Trivia/Word Games | ☐ | ☐ | |
| Reading/Current Events | ☐ | ☐ | |
| Shopping | ☐ | ☐ | |
| Exercise/Walking/Weights | ☐ | ☐ | |
| Music/Instruments/Singing | ☐ | ☐ | |
| Video games/Computers | ☐ | ☐ | |
| Bingo | ☐ | ☐ | |
| Jigsaw Puzzles | ☐ | ☐ | |
| Board/Table games | ☐ | ☐ | |
| Eat out | ☐ | ☐ | |
| Sports | ☐ | ☐ | |
| Drive around/Outings | ☐ | ☐ | |
| Gardening | ☐ | ☐ | |
| Work/Volunteering | ☐ | ☐ | |
| Cooking | ☐ | ☐ | |
| Crafts/Woodworking | ☐ | ☐ | |
| Collecting | ☐ | ☐ | |
| Outdoors | ☐ | ☐ | |
| Hunting/Fishing | ☐ | ☐ | |
| Arts/Crafts/Ceramics | ☐ | ☐ | |
| Swimming | ☐ | ☐ | |
| Socializing | ☐ | ☐ | |
| Children Visists | ☐ | ☐ | |
| Pool/Darts | ☐ | ☐ | |
| Spiritual/religious | ☐ | ☐ | |
| Sewing/Knitting/Crocheting | ☐ | ☐ | |
| Continued Education | ☐ | ☐ | |
| Hobbies | ☐ | ☐ | |
| Cultural Interests | ☐ | ☐ | |
| Group memberships | ☐ | ☐ | |
| Parties | ☐ | ☐ | |
| Pets | ☐ | ☐ | |

Please list any additional interests or information you believe would be helpful:

ADDITIONAL SERVICES / SERVICE PLAN

**Strengths:**

**Needs:**

**Favorite Memory:**

**Personal Goals:**

**Vital Signs**

Blood pressure: Pulse: Respiration: Temperature:

Participant/Caregiver _____Date: _____

Staff _____ Date: _____

Nurse _____ Date: _____