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| The assessment is prepared by | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | | Contact detail: | | | | | |
| Position and profession: | | | | | Date: | | | | | |
| Participant Details | | | | | | | | | | |
| Name: | | |  | | | | | | | |
| NDIS number: | | |  | | | | | | | |
| Plan Dates: | | |  | | | | | | | |
| DOB: | | |  | | | | Gender: | | |  |
| Address: | | |  | | | | State: | | |  |
| Email Address: | | |  | | | | Phone: | | |  |
| Preferred Contact Person: | | |  | | | | | | | |
| Personal Health History | | | | | | | | | | |
| Childhood illness: | | ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever  ☐ Polio | | | | | | | | |
| Immunizations and dates: | | ☐ Tetanus | |  | | ☐ Pneumonia | | |  | |
| ☐ Hepatitis | |  | | ☐ Chickenpox | | |  | |
| ☐ Influenza | |  | | ☐ MMRMeasles, Mumps, Rubella | | | | |
| List any medical problems that other doctors have diagnosed such as  Stroke, Eye Trouble , Rheumatic Fever, Blood Disorder , Seizure Disorder, Pneumonia , Liver Disease , Blood Transfusion, Unconsciousness, Emphysema, Gerd Esophageal Reflux, Broken Bones, Anxiety/, Depression, Asthma, Gallbladder Disease, Arthritis, Other Mental Illness, Sleep Apnea, Diverticulitis, Gout, DVT/PE, (Blood Clot), High Blood Pressure, Kidney Stones, Urinary Tract Infection, Skin Cancer, High Cholesterol, Kidney Disease, Venereal Disease, Other Types of Cancer, Heart Murmur, Thyroid Disease, Breast Lump, Radiation Treatment, Enlarged Heart, Anemia, Exposed to TB, Glaucoma, Heart Attack, Diabetes, Hay Fever | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| Surgeries | | | | | | | | | | |
| Year | Reason | | | | | | | Hospital | | |
|  |  | | | | | | |  | | |
|  |  | | | | | | |  | | |
| Other hospitalizations and Major Illnesses | | | | | | | | | | |
| Year | Reason | | | | | | | Hospital | | |
|  |  | | | | | | |  | | |
|  |  | | | | | | |  | | |

| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name the Drug | | | Strength | | | Frequency Taken | | | | | |
|  | | |  | | |  | | | | | |
|  | | |  | | |  | | | | | |
| Health Habits And Personal Safety | | | | | | | | | | | |
| All questions contained in this questionnaire are optional and will be kept strictly confidential. | | | | | | | | | | | |
| Exercise | ☐ Sedentary (No exercise) | | | | | | | | | | |
| ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | | | | | | | |
| ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | | | | | | | |
| ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | | | | | | | |
| weightloss | Have you had success in previous weight loss? ☐ Yes ☐ No  What was the reason? | | | | | | | | | | |
| Diet | Are you dieting? | | | | | | | ☐ | Yes | ☐ | No |
| If yes, are you on a physician prescribed medical diet? | | | | | | | ☐ | Yes | ☐ | No |
| # Of meals you eat in an average day? | | | | | | | | | | |
| Rank salt intake | ☐ Hi | | ☐ Med | ☐ Low | | | | | | |
| Rank fat intake | ☐ Hi | | ☐ Med | ☐ Low | | | | | | |
| Caffeine | **☐** None | ☐ Coffee | | ☐ Tea | ☐ Cola | | | | | | |
| # Of cups/cans per day? | | | | | | | | | | |
| Alcohol | Do you drink alcohol? | | | | | | | ☐ | Yes | ☐ | No |
| If yes, what kind? | | | | | | | | | | |
| How many drinks per week? | | | | | | | | | | |
| Are you concerned about the amount you drink? | | | | | | | ☐ | Yes | ☐ | No |
| Have you considered stopping? | | | | | | | ☐ | Yes | ☐ | No |
| Have you ever experienced blackouts? | | | | | | | ☐ | Yes | ☐ | No |
| Are you prone to “binge” drinking? | | | | | | | ☐ | Yes | ☐ | No |
| Do you drive after drinking? | | | | | | | ☐ | Yes | ☐ | No |
| Tobacco | Do you use tobacco? | | | | | | | ☐ | Yes | ☐ | No |
| **☐** Cigarettes – pks. /Day | | | **☐** Chew - #/day | **☐** Pipe - #/day | | ☐ Cigars - #/day | | | | |
| **☐** # Of years | ◻ Or year quit | | | | | | | | | |
| Drugs | Do you currently use recreational or street drugs? | | | | | | | ☐ | Yes | ☐ | No |
| Have you ever given yourself street drugs with a needle? | | | | | | | ☐ | Yes | ☐ | No |
| Personal Safety | Do you live alone? | | | | | | | ☐ | Yes | ☐ | No |
| Do you have frequent falls? | | | | | | | ☐ | Yes | ☐ | No |
| Do you have vision or hearing loss? | | | | | | | ☐ | Yes | ☐ | No |
| Do you have an Advance Directive or Living Will? | | | | | | | ☐ | Yes | ☐ | No |
| Would you like information on the preparation of these? | | | | | | | ☐ | Yes | ☐ | No |
| Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | | | | | | | ☐ | Yes | ☐ | No |

| Mental Health | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Is stress a major problem for you? | | | | | | | ☐ | Yes | ☐ | No |
| Do you feel depressed? | | | | | | | ☐ | Yes | ☐ | No |
| Do you panic when stressed? | | | | | | | ☐ | Yes | ☐ | No |
| Do you have problems with eating or your appetite? | | | | | | | ☐ | Yes | ☐ | No |
| Do you cry frequently? | | | | | | | ☐ | Yes | ☐ | No |
| Have you ever attempted suicide? | | | | | | | ☐ | Yes | ☐ | No |
| Have you ever seriously thought about hurting yourself? | | | | | | | ☐ | Yes | ☐ | No |
| Do you have trouble sleeping? | | | | | | | ☐ | Yes | ☐ | No |
| Have you ever been to a counselor? | | | | | | | ☐ | Yes | ☐ | No |
| Personal Hygiene | | | | | | | | | | |
| Toileting | |  | | | | | | | | |
| Showering | |  | | | | | | | | |
| Dressing | |  | | | | | | | | |
| Grooming | |  | | | | | | | | |
| Fingernails | |  | | | | | | | | |
| Oral | |  | | | | | | | | |
| Continence Management | | | | | | | | | | |
| Urinary | |  | | | | | | | | |
| Faecal | |  | | | | | | | | |
| Aids | |  | | | | | | | | |
| Assistance | |  | | | | | | | | |
| Sensory | | | | | | | | | | |
| Vision | |  | | | | | | | | |
| Interventions | |  | | | | | | | | |
| Hearing | |  | | | | | | | | |
| Interventions | |  | | | | | | | | |
| Speech | |  | | | | | | | | |
| Interventions | |  | | | | | | | | |
| Taste | |  | | | | | | | | |
| Touch | |  | | | | | | | | |
| Smell | |  | | | | | | | | |
| Pain Management | | | | | | | | | | |
| Site And Interventions | |  | | | | | | | | |
| Behaviour Management | | | | | | | | | | |
| Cognitive skills | |  | | | | | | | | |
| Wandering | |  | | | | | | | | |
| Verbal behaviour | |  | | | | | | | | |
| Physical behaviour | |  | | | | | | | | |
| Depression | |  | | | | | | | | |
| Other Problem | |  | | | | | | | | |
| Intervention | |  | | | | | | | | |
| Other Problem | | | | | | | | | | |
| Intervention | |  | | | | | | | | |
| Sleep | |  | | | | | | | | |
| Skin Integrity | |  | | | | | | | | |
| Specialised Care | |  | | | | | | | | |
| Medications | |  | | | | | | | | |
| Physiotherapy | |  | | | | | | | | |
| Podiatry | |  | | | | | | | | |
| Social Needs | |  | | | | | | | | |
| Family Support | |  | | | | | | | | |
| Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain. | | | | | | | | | | |
| ☐ | Skin | | ☐ | Chest/Heart | ☐ | Recent changes in: | | | | |
| ☐ | Head/Neck | | ☐ | Back | ☐ | Weight | | | | |
| ☐ | Ears | | ☐ | Intestinal | ☐ | Energy level | | | | |
| ☐ | Nose | | ☐ | Bladder | ☐ | Ability to sleep | | | | |
| ☐ | Throat | | ☐ | Bowel | ☐ | Other pain/discomfort: | | | | |
| ☐ | Lungs | | ☐ | Circulation |  |  | | | | |
|  | | | | | | | | | | |