

# VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

**Dates:**

Screen: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Assessment: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Reassessment: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_



## IDENTIFICATION/BACKGROUND

### Name & Vital Information

Client Name: \_\_\_\_\_ Client SSN: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Phone: \_\_\_\_\_ City/County Code: \_\_\_\_\_

Directions to House: \_\_\_\_\_ Pets? \_\_\_\_\_

### Demographics

Birthdate: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Male <sub>0</sub> \_\_\_\_\_ Female <sub>1</sub>  
(Month) (Day) (Year)

Marital Status: \_\_\_\_\_ Married <sub>0</sub> \_\_\_\_\_ Widowed <sub>1</sub> \_\_\_\_\_ Separated <sub>2</sub> \_\_\_\_\_ Divorced <sub>3</sub> \_\_\_\_\_ Single <sub>4</sub> \_\_\_\_\_ Unknown <sub>9</sub>

**Race:**

\_\_\_\_\_ White <sub>0</sub>  
\_\_\_\_\_ Black/African American <sub>1</sub>  
\_\_\_\_\_ American Indian <sub>2</sub>  
\_\_\_\_\_ Oriental/Asian <sub>3</sub>  
\_\_\_\_\_ Alaskan Native <sub>4</sub>  
\_\_\_\_\_ Unknown <sub>9</sub>  
Ethnic Origin: \_\_\_\_\_

**Education:**

\_\_\_\_\_ Less than High School <sub>0</sub>  
\_\_\_\_\_ Some High School <sub>1</sub>  
\_\_\_\_\_ High School Graduate <sub>2</sub>  
\_\_\_\_\_ Some College <sub>3</sub>  
\_\_\_\_\_ College Graduate <sub>4</sub>  
\_\_\_\_\_ Unknown <sub>9</sub>  
Specify: \_\_\_\_\_

**Communication of Needs:**

\_\_\_\_\_ Verbally, English <sub>0</sub>  
\_\_\_\_\_ Verbally, Other Language <sub>1</sub>  
Specify: \_\_\_\_\_  
\_\_\_\_\_ Sign Language/Gestures/Device <sub>2</sub>  
\_\_\_\_\_ Does Not Communicate <sub>3</sub>  
Hearing Impaired? \_\_\_\_\_

### Primary Caregiver/Emergency Contact/Primary Physician

Name: \_\_\_\_\_ Relationships: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ (H) \_\_\_\_\_ (W)  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ (H) \_\_\_\_\_ (W)  
Name of Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

### Initial Contact

Who called: \_\_\_\_\_  
(Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis: \_\_\_\_\_

Client Name:

Client SSN:

### Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	(Check All Services That Apply)	Provider/Frequency:
_____	_____	Adult Day Care	_____
_____	_____	Adult Protective	_____
_____	_____	Case Management	_____
_____	_____	Chore/Companion/Homemaker	_____
_____	_____	Congregate Meals/Senior Center	_____
_____	_____	Financial Management/Counseling	_____
_____	_____	Friendly Visitor/Telephone Reassurance	_____
_____	_____	Habilitation/Supported Employee	_____
_____	_____	Home Delivered Meals	_____
_____	_____	Home Health/Rehabilitation	_____
_____	_____	Home Repairs/Weatherization	_____
_____	_____	Housing	_____
_____	_____	Legal	_____
_____	_____	Mental Health (Inpatient/Outpatient)	_____
_____	_____	Mental Retardation	_____
_____	_____	Personal Care	_____
_____	_____	Respite	_____
_____	_____	Substance Abuse	_____
_____	_____	Transportation	_____
_____	_____	Vocational Rehab/Job Counseling	_____
_____	_____	Other:	_____

### Financial Resources

Where are you on the scale for annual (monthly) family income before taxes?

_____	\$20,000 or More	(\$1,667 or more ) 0
_____	\$15,000 - 19,999	(\$1,250 - \$1,666) 1
_____	\$11,000 - 14,999	(\$ 917 - \$1,249) 2
_____	\$ 9,500 - 10,999	(\$ 792 - \$ 916) 3
_____	\$ 7,000 - 9,499	(\$ 583 - \$ 791) 4
_____	\$ 5,500 - 6,999	(\$ 458 - \$ 582) 5
_____	\$ 5,499 or Less	(\$ 457 or Less ) 6
_____	Unknown	9

Number in Family unit: \_\_\_\_\_  
Optional: Total monthly family income: \_\_\_\_\_

Do you currently receive income from...?

No 0	Yes 1	Optional: Amount
_____	_____	Black Lung _____
_____	_____	Pension _____
_____	_____	Social Security _____
_____	_____	SSI/SSDI _____
_____	_____	VA Benefits _____
_____	_____	Wages/Salary _____
_____	_____	Other _____

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1	Names
_____	_____	Legal Guardian _____
_____	_____	Power of Attorney _____
_____	_____	Representative Payee _____
_____	_____	Other _____

Do you receive any benefits or entitlements?

No 0	Yes 1	
_____	_____	Auxiliary Grant
_____	_____	Food Stamps
_____	_____	Fuel Assistance
_____	_____	General Relief
_____	_____	State and Local Hospitalization
_____	_____	Subsidized Housing
_____	_____	Tax Relief

What types of health insurance do you have?

No 0	Yes 1	
_____	_____	Medicare, # _____
_____	_____	Medicaid, # _____
_____	_____	Pending: _____ No 0 _____ Yes 1
_____	_____	QMB/SLMB: _____ No 0 _____ Yes 1
_____	_____	All Other Public/Private: _____

Client Name:

Client SSN:

**Physical Environment**

**Where do you usually live? Does anyone live with you?**

	Alone <sub>1</sub>	Spouse <sub>2</sub>	Other <sub>3</sub>	Names of Persons in Household	
<input type="checkbox"/> House: Own <sub>0</sub>					
<input type="checkbox"/> House: Rent <sub>1</sub>					
<input type="checkbox"/> House: Other <sub>2</sub>					
<input type="checkbox"/> Apartment <sub>3</sub>					
<input type="checkbox"/> Rented Room <sub>4</sub>					
	Name of Provider (Place)			Admission Date	Provider Number (If Applicable)
<input type="checkbox"/> Adult Care Residence <sub>50</sub>					
<input type="checkbox"/> Adult Foster <sub>60</sub>					
<input type="checkbox"/> Nursing Facility <sub>70</sub>					
<input type="checkbox"/> Mental Health/Retardation Facility <sub>80</sub>					
<input type="checkbox"/> Other <sub>90</sub>					

**Where you usually live are there any problems?**

No <sub>0</sub>	Yes <sub>1</sub>	(Check All Problems That Apply)	Describe Problems:
<input type="checkbox"/>	<input type="checkbox"/>	Barriers to Access	
<input type="checkbox"/>	<input type="checkbox"/>	Electric Hazards	
<input type="checkbox"/>	<input type="checkbox"/>	Fire Hazards/No Smoke Alarm	
<input type="checkbox"/>	<input type="checkbox"/>	Insufficient Heat/Air Conditioning	
<input type="checkbox"/>	<input type="checkbox"/>	Insufficient Hot Water/Water	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of/Poor Toilet Facilities (Inside/Outside)	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of/Defective Stove, Refrigerator, Freezer	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of/Defective Washer/Dryer	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of/Poor Bathing Facilities	
<input type="checkbox"/>	<input type="checkbox"/>	Structural Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Telephone Not Accessible	
<input type="checkbox"/>	<input type="checkbox"/>	Unsafe Neighborhood	
<input type="checkbox"/>	<input type="checkbox"/>	Unsafe/Poor Lighting	
<input type="checkbox"/>	<input type="checkbox"/>	Unsanitary Conditions	
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	

Client Name: \_\_\_\_\_

Client SSN: \_\_\_\_\_

**2**

**FUNCTIONAL STATUS** (Check only one block for each level of functioning.)

ADLS	Needs Help?	
	No <sub>00</sub>	Yes
Bathing		
Dressing		
Toileting		
Transferring		
Eating/Feeding		

Continance	Needs Help?	
	No <sub>00</sub>	Yes
Bowel		
Bladder		

Ambulation	Needs Help?	
	No <sub>00</sub>	Yes
Walking		
Wheeling		
Stairclimbing		
Mobility		

IADLS	Needs Help?	
	No <sub>0</sub>	Yes <sub>1</sub>
Meal Preparation		
Housekeeping		
Laundry		
Money Mgmt.		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50	
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2			
					Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3

Incontinent Less than Weekly 1	Ext. Device/ Indwelling/ Ostomy Self Care 2	Incontinent D Weekly or More 3	External Device Not Self Care 4	Indwelling D Catheter Not Self Care 5	Ostomy D Not Self Care 6

MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
					<b>Confined</b> Moves About	<b>Confined</b> Does Not Move About

Comments: \_\_\_\_\_

**Outcome: Is this a short assessment?**

\_\_\_\_\_ No, Continue with Section 3 (0)      \_\_\_\_\_ Yes, Service Referrals (1)      \_\_\_\_\_ Yes, No Service Referrals (2)

Screener: \_\_\_\_\_ Agency: \_\_\_\_\_

Client Name:

Client SSN:

# PHYSICAL HEALTH ASSESSMENT

## Professional Visits/Medical Admissions

Doctor's Name(s) (List all)	Phone	Date of Last Visit	Reason for Last Visit

### Admission: In the past 12 months have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1	Name of Place	Admit Date	Length of Stay/Reason
		Hospital		
		Nursing Facility		
		Adult Care Residence		

### Do you have any advance directives such as... (Who has it...Where is it...)?

No 0 Yes 1 Location

\_\_\_\_\_ Living Will, \_\_\_\_\_

\_\_\_\_\_ Durable Power of Attorney for Health Care, \_\_\_\_\_

\_\_\_\_\_ Other, \_\_\_\_\_

## Diagnoses & Medication Profile

### Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as ... (Refer to the list of diagnoses)?

Current Diagnoses	Date of Onset	Diagnoses:
		Alcoholism/Substance Abuse (01)
		Blood-Related Problems (02)
		Cancer (03)
		Cardiovascular Problems
		Circulation (04)
		Heart Trouble (05)
		High Blood Pressure (06)
		Other Cardiovascular Problems (07)
		Dementia
		Alzheimer's (08)
		Non-Alzheimer's (09)
		Developmental Disabilities
		Mental Retardation (10)
		Related Conditions
		Autism (11)
		Cerebral Palsy (12)
		Epilepsy (13)
		Friedreich's Ataxia (14)
		Multiple Sclerosis (15)
		Muscular Dystrophy (16)
		Spina Bifida (17)
		Digestive/Liver/Gall Bladder (18)
		Endocrine (Gland)Problems
		Diabetes (19)
		Other Endocrine Problem (20)
		Eye Disorders (21)
		Immune System Disorders (22)
		Muscular/Skeletal
		Arthritis/Rheumatoid Arthritis (23)
		Osteoporosis (24)
		Other Muscular/Skeletal Problems (25)
		Neurological Problems
		Brain Trauma/Injury (26)
		Spinal Cord Injury (27)
		Stroke (28)
		Other Neurological Problems (29)
		Psychiatric Problems
		Anxiety Disorder (30)
		Bipolar (31)
		Major Depression (32)
		Personality Disorder (33)
		Schizophrenia (34)
		Other Psychiatric Problems (35)
		Respiratory Problems
		Black Lung (36)
		COPD (37)
		Pneumonia (38)
		Other Respiratory Problems (39)
		Urinary/Reproductive Problems
		Renal Failure (40)
		Other Urinary /Reproductive (41)
		All Other Problems (42)

Enter Codes for 3 Major, Active Diagnoses: \_\_\_\_\_ None<sub>00</sub> \_\_\_\_\_ DX1 \_\_\_\_\_ DX2 \_\_\_\_\_ DX3

Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		

Total No. of Medications: \_\_\_\_\_ (If 0, skip to Sensory Function) Total No. of Tranquilizer/Psychotropic Drugs: \_\_\_\_\_

Do you have any problems with medicine(s)...?	How do you take your medications?
No 0 Yes 1	_____ Without assistance 0
_____ Adverse reactions/allergies	_____ Administered/monitored by lay person 1
_____ Cost of medication	_____ Administered/monitored by professional nursing staff 2
_____ Getting to the pharmacy	Describe help: _____
_____ Taking them as instructed/prescribed	Name of helper: _____
_____ Understanding directions/schedule	

Client Name: \_\_\_\_\_

Client SSN: \_\_\_\_\_

## Sensory Functions

### How is your vision, hearing, and speech?

	No Impairment <sub>0</sub>	Impairment		Complete Loss <sub>3</sub>	Date of Last Exam
		Record Date of Onset/Type of Impairment			
		Compensation <sub>1</sub>	No Compensation <sub>2</sub>		
Vision					
Hearing					
Speech					

## Physical Status

### Joint Motion: How is your ability to move your arms, fingers, and legs?

- \_\_\_\_\_ Within normal limits or instability corrected <sub>0</sub>
- \_\_\_\_\_ Limited motion <sub>1</sub>
- \_\_\_\_\_ Instability uncorrected or immobile <sub>2</sub>

### Have you ever broken or dislocated any bones ... Ever had an amputation or lost any limbs ... Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
<input type="checkbox"/> None 000 <input type="checkbox"/> Hip Fracture 1 <input type="checkbox"/> Other Broken Bone(s) 2 <input type="checkbox"/> Dislocation(s) 3 <input type="checkbox"/> Combination 4 <b>Previous Rehab Program?</b> <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 <b>Date of Fracture/Dislocation?</b> <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> None 000 <input type="checkbox"/> Finger(s)/Toe(s) 1 <input type="checkbox"/> Arm(s) 2 <input type="checkbox"/> Leg(s) 3 <input type="checkbox"/> Combination 4 <b>Previous Rehab Program?</b> <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 <b>Date of Amputation?</b> <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> None 000 <input type="checkbox"/> Partial 1 <input type="checkbox"/> Total 2 Describe: _____ <b>Previous Rehab Program?</b> <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 <b>Onset of Paralysis?</b> <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2

## Nutrition

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Recent Weight Gain/Loss: \_\_\_\_\_ No <sub>0</sub> \_\_\_\_\_ Yes <sub>1</sub>  
 (Inches) (lbs.) Describe: \_\_\_\_\_

Are you on any special diet(s) for medical reasons?	Do you have any problems that make it hard to eat?
<input type="checkbox"/> None 0 <input type="checkbox"/> Low Fat/Cholesterol 1 <input type="checkbox"/> No/Low Salt 2 <input type="checkbox"/> No/Low Sugar 3 <input type="checkbox"/> Combination/Other 4	No <sub>0</sub> Yes <sub>1</sub> <input type="checkbox"/> _____ Food Allergies <input type="checkbox"/> _____ Inadequate Food/Fluid Intake <input type="checkbox"/> _____ Nausea/Vomiting/Diarrhea <input type="checkbox"/> _____ Problems Eating Certain Foods <input type="checkbox"/> _____ Problems Following Special Diets <input type="checkbox"/> _____ Problems Swallowing <input type="checkbox"/> _____ Taste Problems <input type="checkbox"/> _____ Tooth or Mouth Problems <input type="checkbox"/> _____ Other: _____
<b>Do you take dietary supplements?</b> <input type="checkbox"/> None 0 <input type="checkbox"/> Occasionally 1 <input type="checkbox"/> Daily, Not Primary Source 2 <input type="checkbox"/> Daily, Primary Source 3 <input type="checkbox"/> Daily, Sole Source 4	

Client Name: \_\_\_\_\_

Client SSN: \_\_\_\_\_

### Current Medical Services

#### Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as...?

No <sub>0</sub>	Yes <sub>1</sub>	Frequency
_____	_____	Occupational _____
_____	_____	Physical _____
_____	_____	Reality/Remotivation _____
_____	_____	Respiratory _____
_____	_____	Speech _____
_____	_____	Other _____

#### Special Medical Procedures: Do you receive any special nursing care, such as ...?

No <sub>0</sub>	Yes <sub>1</sub>	Site, Type, Frequency
_____	_____	Bowel/Bladder Training _____
_____	_____	Dialysis _____
_____	_____	Dressing/Wound Care _____
_____	_____	Eye care _____
_____	_____	Glucose/Blood Sugar _____
_____	_____	Injections/IV Therapy _____
_____	_____	Oxygen _____
_____	_____	Radiation/Chemotherapy _____
_____	_____	Restraints (Physical/Chemical) _____
_____	_____	ROM Exercise _____
_____	_____	Trach Care/Suctioning _____
_____	_____	Ventilator _____
_____	_____	Other: _____

#### Do you have pressure ulcers?

None <sub>0</sub>	Location/Size
_____	_____
_____	Stage I 1 _____
_____	Stage II 2 _____
_____	Stage III 3 _____
_____	Stage IV 4 _____

### Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? \_\_\_\_\_ No <sub>0</sub> \_\_\_\_\_ Yes <sub>1</sub>

#### If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

#### Comments:

Optional: Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Others: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature/Title)

Client Name:

Client SSN:

# 4 PSYCHO-SOCIAL ASSESSMENT

## Cognitive Function

**Orientation** (Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)

**Person:** Please tell me your full name (so that I can make sure our record is correct).  
**Place:** Where are we now (*state, county, town, street/route number, street name/box number*)? Give the client 1 point for each correct response.  
**Time:** Would you tell me the date today (*year, season, date, day, month*)?

Oriented 0

Disoriented – Some spheres, some of the time 1

Disoriented – Some spheres, all the time 2

Disoriented – All spheres, some of the time 3

Disoriented – All spheres, all of the time 4

Comatose 5

Spheres affected: \_\_\_\_\_

Optional: MMSE Score
(5)
(5)
(3)
(5)
Total:
<b>Note:</b> Score of 14 or below implies cognitive impairment.

## Recall/Memory/Judgment

**Recall:** I am going to say three words. And I want you to repeat them after I am done ( House, Bus,Dog). \* Ask the client to repeat them. Give the client 1 point for each correct response on the first trial. \* Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

**Attention/Concentration:** Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).

**Short-Term:** \* Ask the client to recall the 3 words he was to remember.

**Long-Term:** When were you born ( What is your date of birth)?

**Judgment:** If you needed help at night, what would you do?

No 0 Yes 1

\_\_\_\_\_ Short-Term Memory Loss?

\_\_\_\_\_ Long-Term Memory Loss?

\_\_\_\_\_ Judgment Problems?

## Behavior Pattern

**Does the client ever wander without purpose (trespass, get lost, go into traffic, etc...) or become agitated and abusive?**

Appropriate 0

Wandering/Passive – Less than weekly 1

Wandering/Passive – Weekly or more 2

Abusive/Aggressive/Disruptive – Less than weekly 3

Abusive/Aggressive/Disruptive – Weekly or more 4

Comatose 5

Type of inappropriate behavior: \_\_\_\_\_ Source of Information: \_\_\_\_\_

## Life Stressors

**Are there any stressful events that currently affect your life, such as ...?**

No 0 Yes 1

\_\_\_\_\_ Change in work/employment

\_\_\_\_\_ Death of someone close

\_\_\_\_\_ Family conflict

No 0 Yes 1

\_\_\_\_\_ Financial problems

\_\_\_\_\_ Major illness- family/friend

\_\_\_\_\_ Recent move/relocation

No 0 Yes 1

\_\_\_\_\_ Victim of a crime

\_\_\_\_\_ Failing health

Other: \_\_\_\_\_



Client Name:

Client SSN:

**Emotional Status**

In the past month, how often did you ...?	Rarely/ Never <sub>0</sub>	Some of the Time <sub>1</sub>	Often <sub>2</sub>	Most of the Time <sub>3</sub>	Unable to Assess <sub>9</sub>
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you don't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living ... or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite ... that is, eat too much or too little?					

**Comments:**

**Social Status**

**Are there some things that you do that you especially enjoy?**

No <sub>0</sub>      Yes <sub>1</sub>

*Describe*

\_\_\_\_\_ Solitary Activities, \_\_\_\_\_

\_\_\_\_\_ With Friends/Family, \_\_\_\_\_

\_\_\_\_\_ With Groups/Clubs, \_\_\_\_\_

\_\_\_\_\_ Religious Activities, \_\_\_\_\_

**How often do you talk with your children family or friends either during a visit or over the phone?**

**Children**

**Other Family**

**Friends/ Neighbors**

\_\_\_\_\_ No Children 0

\_\_\_\_\_ No Other Family 0

\_\_\_\_\_ No Friends/Neighbors 0

\_\_\_\_\_ Daily 1

\_\_\_\_\_ Daily 1

\_\_\_\_\_ Daily 1

\_\_\_\_\_ Weekly 2

\_\_\_\_\_ Weekly 2

\_\_\_\_\_ Weekly 2

\_\_\_\_\_ Monthly 3

\_\_\_\_\_ Monthly 3

\_\_\_\_\_ Monthly 3

\_\_\_\_\_ Less than Monthly 4

\_\_\_\_\_ Less than Monthly 4

\_\_\_\_\_ Less than Monthly 4

\_\_\_\_\_ Never 5

\_\_\_\_\_ Never 5

\_\_\_\_\_ Never 5

**Are you satisfied with how often you see or hear from your children other family and/or friends?**

\_\_\_\_\_ No 0

\_\_\_\_\_ Yes 1

Client Name:

Client SSN:

### Hospitalization/Alcohol – Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves emotional/mental health alcohol or substance abuse problems?

\_\_\_\_\_ No 0

\_\_\_\_\_ Yes 1

Name of Place	Admit Date	Length of stay/Reason

**Do (did) you ever drink alcoholic beverages?**

**Do (did) you ever use non-prescription, mood altering substances?**

\_\_\_\_\_ Never 0

\_\_\_\_\_ At one time, but no longer 1

\_\_\_\_\_ Currently 2

How much: \_\_\_\_\_

How often: \_\_\_\_\_

\_\_\_\_\_ Never 0

\_\_\_\_\_ At one time, but no longer 1

\_\_\_\_\_ Currently 2

How much: \_\_\_\_\_

How often: \_\_\_\_\_

*If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.*

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?	Do (did) you ever use alcohol/other mood-altering substances with ...	Do (did) you ever use alcohol/other mood-altering substances to help you ...
_____ No 0      _____ Yes 1	No 0      Yes 1	No 0      Yes 1
<b>Describe concerns:</b>	_____ Prescription drugs? _____ OTC medicine? _____ Other substances?	_____ Sleep? _____ Relax? _____ Get more energy? _____ Relieve worries? _____ Relieve physical pain?
	<b>Describe what and how often:</b>	<b>Describe what and how often:</b>

**Do (did) you ever smoke or use tobacco products?**

\_\_\_\_\_ Never 0

\_\_\_\_\_ At one time, but no longer 1

\_\_\_\_\_ Currently 2

How much: \_\_\_\_\_

How often: \_\_\_\_\_

**Is there anything we have not talked about that you would like to discuss?**

Client Name:

Client SSN:



## Assessment Summary

*Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1-55.3, to report this to the Department of Social Services, Adult Protective Services.*

### Caregiver Assessment

#### Does the client have an informal caregiver?

\_\_\_\_\_ No 0 (Skip to Section on Preferences)      \_\_\_\_\_ Yes 1

#### Where does the caregiver live?

\_\_\_\_\_ With client 0  
\_\_\_\_\_ Separate residence, close proximity 1  
\_\_\_\_\_ Separate residence, over 1 hour away 2

#### Is the caregiver's help ...

\_\_\_\_\_ Adequate to meet the client's needs? 0  
\_\_\_\_\_ Not adequate to meet the client's needs? 1

#### Has providing care to client become a burden for the caregiver?

\_\_\_\_\_ Not at all 0  
\_\_\_\_\_ Somewhat 1  
\_\_\_\_\_ Very much 2

#### Describe any problems with continued caregiving:

### Preferences

Client's preference for receiving needed care: \_\_\_\_\_

Family/Representative's preference for client's care: \_\_\_\_\_

Physician's comments (if applicable): \_\_\_\_\_

Client Name:

Client SSN:

**Client Case Summary**

[Empty box for Client Case Summary]

**Unmet Needs**

No <sub>0</sub> Yes <sub>1</sub> (Check All That Apply)

- \_\_\_\_\_ \_\_\_\_\_ Finances
- \_\_\_\_\_ \_\_\_\_\_ Home/Physical Environment
- \_\_\_\_\_ \_\_\_\_\_ ADLS
- \_\_\_\_\_ \_\_\_\_\_ IADLS

No <sub>0</sub> Yes <sub>1</sub> (Check All That Apply)

- \_\_\_\_\_ \_\_\_\_\_ Assistive Devices/Medical Equipment
- \_\_\_\_\_ \_\_\_\_\_ Medical Care/Health
- \_\_\_\_\_ \_\_\_\_\_ Nutrition
- \_\_\_\_\_ \_\_\_\_\_ Cognitive/Emotional
- \_\_\_\_\_ \_\_\_\_\_ Caregiver Support

**Assessment Completed By:**

Assessor's Name	Signature	Agency/Provider Name	Provider #	Section(s) Completed

Optional: Case assigned to: \_\_\_\_\_ Code #: \_\_\_\_\_