Initial Health Assessment

Client Name		**MSSP #**	
Assessment Date		**Staff Code**	
Staff Signature / Title			

Diagnosis / Medical History

What are the client's diagnoses?

What is the client's medical history?

What is the client's rating of his/her own health?

☐ Poor	☐ Fair	☐ Good	☐ Excellent

Has client been in a hospital, SNF or ER in past year?	☐ No	☐ Yes

If Yes, provide approximate date(s) and reason(s):

Medications

Pharmacy used:

☐ Allergies to medications	☐ Forgets medications	☐ Problem with cost

☐ Medications prescribed are covered by Medicare	☐ Has prescription medications in stock which are no longer prescribed

☐ Primary physician knows about all of client's medications

☐ Does client have help with medications?	☐ No	☐ Yes

If yes, who helps?

What kind of help?

Medications continued

Is more help with medications needed?	☐ No	☐ Yes
If yes, describe:		
Comments S/O		

Nutritional Assessment

Y = Yes	N = No	D = Deferred

Include in your assessment:

- Usual eating
- Diet patterns
- Preparation of meals
- Shopping
- Finances
- Allergies

☐ Weight loss or gain in past year:

☐ Special diet/restricted foods:

☐ Client follows diet:

Client's appetite (subjective):

☐ Good	☐ Fair	☐ Poor

Meals per day:	☐ 1	☐ 2	☐ 3

Assessment of client's diet quality (objective):

☐ Good	☐ Fair	☐ Poor

Nutritional Supplements?

Approximate amount/type of fluid intake:

Comments S/O

Health Habits

Y = Yes	N = No	D = Deferred
Describe usual use patterns and significant changes:		
☐ Tobacco	☐ Caffeine	☐ Alcohol
☐ HX of alcohol/drug abuse	Sleep pattern	
Comments S/O		

Review of Systems

Instructions: Check each condition identified by client or observed during the assessment. Inquire about each area as appropriate, and enter response or indicate if not a problem. It is necessary to record a response to each condition. Comments should include changes and impact of condition on function.

S=Subjective	O=Objective

Eyes/Ears/Mouth

Eyes

☐ Glasses or contact lens	☐ Trouble with vision
☐ Change in vision in last year	
Comments S/O	

Ears

☐ Trouble with hearing	☐ Wears a hearing aid
Comments S/O	

Mouth

☐ Problems with teeth/gums	☐ Dentures
☐ Problems with dentures	☐ Dentures fit well
Comments S/O	

Respiratory/Pulmonary

☐ Short of breath	☐ Uses oxygen
☐ Coughs frequently	☐ DX of tuberculosis
Comments S/O	

Cardiovascular

☐ Pain, tightness, or pressure in chest, neck, or arms
☐ Swelling of feet or ankles

☐ Prop pillows at night for shortness of breath		
☐ Fainting/blackouts		
☐ Rapid, irregular, or skipped heartbeats		
☐ High blood pressure		
☐ Cramps in leg muscles	☐When walking	☐When not walking
Comments S/O		

Breasts	
☐ Lumps	
☐ Mammogram	Approximate Date
☐ Performs breast self-exam	
Comments S/O	

Gastrointestinal		
☐ Trouble swallowing	☐ Indigestion/heartburn	☐ Nausea/vomiting
☐ Constipation	☐ Change in bowel habits	☐ Loose stools or diarrhea
☐ Blood from rectum	☐ Bowel incontinence	☐ Black or tarry stools
Comments S/O		

Genitourinary		
☐ HX Bladder disease	☐ Catheter	☐ Incontinence
☐ Frequency at night	☐ Urgency	
☐ Trouble starting/stopping urine	☐ Pain/burning with urination	
Comments S/O		

Vaginal Problems				
☐ Bleeding	☐ Discharge	☐ Odor	☐ Bulging	☐ Itching
Comments S/O				

Testicular / Prostate Problems
Comments S/O

Musculoskeletal

☐ Back pain	☐ Falls	☐ Osteoporosis	☐ Joint pain or stiffness	
☐ Engages in physical activities		☐ Changes in activity level		☐ Foot problems
Comments S/O				
Mobility				
☐ Fully ambulatory		☐ Ambulatory with assistance		☐ Cane/walker
☐ Prosthesis/appliance		☐ Occasional Wheelchair use		☐ Bed Bound
Gait (if observed):				
☐ Ataxia	☐ Unsteady	☐ Poor Balance	☐ Shuffling	☐ Wide Based
Describe need for foot care:				
If bed bound describe ROM:				
Joint deformity description:				
Comments S/O				
Neurological				
☐ CVA	☐ Numbness in arm, leg or face		☐ Trouble finding words/slurred speech	
☐ Paralysis		☐ Headaches		☐ Dizziness
☐ Tremors		☐ Weakness		☐ Seizures
Comments S/O				
Psychiatric				
☐ Confused		☐ Wanders		☐ Feelings of Depression
☐ Psychiatric HX				
☐ Changes in memory				
Comments S/O				
Endocrine				
☐ Diabetes		☐ Insulin Dependent		☐ Controlled Diet
☐ Oral Hypoglycemics			☐ Thyroid Problems	
Comments S/O				
Skin				
☐ Rash	☐ Dry skin	☐ Itching		☐ Growths
☐ Changes in wart or mole			☐ Wounds/lesions	
☐ Sores that will not heal				

Skin characteristics:				
☐ Warm	☐ Cool	☐ Dry	☐ Moist	☐ Color
Comments S/O				

Vital Signs	
Temperature (optional)	Respiration
Pulse	BP (indicate position)
Weight (history or taken)	Height (by history)
Comments S/O	
Who provided assessment information?	
☐ Client ☐ Caregiver ☐ Family	
☐ Other	
Comments S/O	
How reliable is provided information?	
Was this Assessment conducted in the client's home?	
☐ Yes	☐ No (if no, where?)