Initial Health Assessment

Instructions: Inquire about each area as appropriate, and enter response or indicate if not applicable in the comments. It is necessary to record a response to each area of the assessment.

Participant Name: _____ MSSP #_____
Assessment Date: _____ Staff Code: _____
Staff Signature/Title: _____

Diagnosis/Medical History

What are the participant's diagnoses?

What is the participant's medical history?

What is the participant's rating of own health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Has the participant been in a hospital, SNF, or ER in past year? ☐ Yes ☐ No
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 and/or expired
☐ Primary physician knows about all of the participant's medications

Does the participant have help with medications? ☐ Yes ☐ No
If yes, who helps? What kind of help?

Is more help with medications needed? ☐ Yes ☐ No
If yes, describe

Comments (Subjective/Objective)

Nutritional Assessment

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:

☐ Participant follows diet:

Participant's appetite (subjective): ☐ Good ☐ Fair ☐ Poor

Meals per day: ☐ 1 ☐ 2 ☐ 3

Assessment of participant's diet quality? (objective):

Nutritional Supplements?

Approximate amount/type of fluid intake:

Comments (Subjective/Objective)

Health Habits

Describe usual use patterns and significant changes:

☐ Tobacco

☐ Caffeine

☐ Alcohol

☐ History of alcohol/drug abuse

Sleep Pattern

Comments (Subjective/Objective)

Review of Systems

Instructions: Check each condition identified by participant or observed during the assessment. Inquire about each area as appropriate and enter response or indicate if not a problem by stating “none” or “N/A”. It is necessary to record a response to each condition. Comments should include changes, impact of condition on function, and whether a medical care provider is overseeing the participant’s care. For example, if the participant is seeing a cardiologist, this should be listed in the comment box in the cardiovascular section.

Eyes: ☐ Glasses or Contact lens ☐ Trouble with vision ☐ Change in vision in last year
Comments (Subjective/Objective)

Ears: ☐ Trouble with hearing ☐ Wears a hearing aid
Comments (Subjective/Objective)

Mouth: ☐ Problems with teeth/gums ☐ Dentures ☐ Problems with Dentures
☐ Dentures fit well
Comments (Subjective/Objective)

Respiratory/Pulmonary: ☐ Short of Breath ☐ Uses Oxygen ☐ Coughs Frequently
☐ DX of Tuberculosis ☐ Uses Inhaler
Comments (Subjective/Objective)

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 (Subjective/Objective)

Breasts: ☐ History of Breast Cancer ☐ Lumps ☐ Mammogram _____ Approx. Date
☐ Performs Breast Self-Exam
Comments (Subjective/Objective)

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 (Subjective/Objective)

Genitourinary: ☐ HX bladder disease ☐ Catheter ☐ Incontinence
☐ Frequency at night ☐ Urgency ☐ Trouble starting/stopping urine
☐ Pain/burning with urination ☐ Chronic UTIs
Comments (Subjective/Objective)

Vaginal Problems: ☐ Bleeding ☐ Discharge ☐ Odor ☐ Bulging ☐ Itching
Comments (Subjective/Objective)

Testicular/Prostate:
Comments (Subjective/Objective)

Musculoskeletal ☐ Back pain ☐ Falls ☐ Osteoporosis ☐ Joint pain or stiffness
☐ Engages in physical activities ☐ Changes in activity level ☐ Foot problems
Comments (Subjective/Objective)

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

Describer need for foot care:

If bed bound describe ROM:

Joint deformity description:

Comments (Subjective/Objective)

Neurological: ☐ CVA ☐ Numbness in arm, leg or face ☐ Paralysis ☐ Headaches
☐ Trouble finding words/slurred speech ☐ Dizziness ☐ Tremors
☐ Weakness ☐ Seizures
Comments (Subjective/Objective)

Psychiatric : ☐ Confused ☐ Wanders ☐ Feelings of Depression
☐ Psychiatric HX ☐ Changes in Memory
Comments (Subjective/Objective)

Endocrine: ☐ Diabetes ☐ Insulin Dependent ☐ Controlled Diet
☐ Oral Hypoglycemics ☐ Thyroid Problems
Comments (Subjective/Objective)

Skin: ☐ Rash/Redness ☐ Dry Skin ☐ Itching ☐ Growths
☐ Changes in wart or mole ☐ Wounds/lesions
☐ Sores that will not heal/pressure injuries
Skin characteristics:
☐ Warm ☐ Cool ☐ Dry ☐ Moist ☐ Color
Comments (Subjective/Objective)

Vital Signs: Temperature (optional) _____ Pulse _____
Respiration _____ BP (indicate position) _____
Weight (history or taken) _____ Height (by history) _____
Pain Level (optional) _____
☐ No Pain ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe ☐ Worst Pain Possible
Comments (Subjective/Objective)

Who provided assessment information: ☐ Participant ☐ Caregiver ☐ Family ☐ Other
Comments (Subjective/Objective)

How reliable is provided information?

Was this assessment conducted in the participant's home? ☐ Yes ☐ No
(if no, where?)

Participant Needs List:

X _____ _____ _____
Staff Signature Date Print Name/Title