

Assisted Living Assessment Tool

PATIENT INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy
Gender: _____ Contact Information: _____
Emergency Contact: _____ Relationship Status: _____

MEDICAL HISTORY

Chronic Illnesses:

Medications:

Allergies:

Past Surgeries:

Family Medical History:

PHYSICAL HEALTH ASSESSMENT

Blood Pressure: _____ Heart Rate: _____
Respiratory Rate: _____

Mobility:

Vision:

Hearing:

Nutritional Status:

COGNITIVE ABILITIES

Memory Test:

Attention Span:

Orientation:

Problem-Solving Skills:

EMOTIONAL WELL-BEING

Mood:

Anxiety Levels:

Social Interactions:

Hobbies/Interests:

Support System:

DAILY LIVING SKILLS

Ability to Perform ADLs:

Instrumental ADLs:

SPECIAL NEEDS & PREFERENCES

Dietary Preferences:

Cultural Needs:

Religious Practices:

Pets:

Other Personal Preferences:

TESTS & SCREENINGS

Blood Tests:

X-rays:

Mental Health Screenings:

Other Relevant Tests:

FINDINGS & INTERPRETATIONS

Summary:

Recommendations:

OVERALL INTERPRETATION

Comprehensive Summary:

Recommendations for Assisted Living: