



## Spend-A-Day

### Adult Day Health Center

Health Assessment  
Page 1

Date:

Client's Name:	SSN:
Street Address:	Phone:
City, State & Zip:	Date of Birth:

**THIS IS TO BE FILLED IN BY PHYSICIAN AT YOUR APPOINTMENT:**

Functional Limitations:
<input type="checkbox"/> Colostomy <input type="checkbox"/> Cane/Walker <input type="checkbox"/> Speech <input type="checkbox"/> Hearing Aid
<input type="checkbox"/> Wheelchair <input type="checkbox"/> Paralysis <input type="checkbox"/> Hearing <input type="checkbox"/> Glasses
<input type="checkbox"/> Amputee <input type="checkbox"/> Arthritis <input type="checkbox"/> Vision <input type="checkbox"/> Language Barrier

Mental Status:	<input type="checkbox"/> Alert	<input type="checkbox"/> Agitated		
	<input type="checkbox"/> Cooperative	<input type="checkbox"/> Variably Cooperative	<input type="checkbox"/> Uncooperative	
	Oriented	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
	Confused	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
	<input type="checkbox"/> Anxious	<input type="checkbox"/> Wandering		
	<input type="checkbox"/> Depressed	<input type="checkbox"/> Withdrawn		

Diagnosis, Pertinent Medical/Surgical History(include TB, seizures, mental illness, diabetes, heart problems, etc.):	_____
	_____
	_____
Allergies:	_____

Current Meds/Dosages:
<input type="checkbox"/> Self Administer _____
<input type="checkbox"/> Nurse Administer _____
<input type="checkbox"/> Family Administer _____
Diet: <input type="checkbox"/> Regular <input type="checkbox"/> No Added Salt <input type="checkbox"/> House Diabetic <input type="checkbox"/> Renal

Pertinent Exam:	Ht. _____	Wt. _____	BP _____	Pulse _____	Edema	0+ _____
HEENT	_____	Breast	_____			1+ _____
Neck	_____	Genitalia	_____			2+ _____
Chest	_____	Rectal	_____			3+ _____
Cor.	_____	Neuro	_____			
Abd.	_____	Extremities	_____			



Client's Name: \_\_\_\_\_

<b>Fever</b>	Tylenol 650mg q4h p.o. for temperature greater than 99.6 (or as directed by physician). Notify physician for temperatures > 100 degrees.
<b>Pain</b>	Tylenol 650mg p.o. q 4 hours for up to 3 doses at discretion of nurse.
<b>Digestive Upset</b>	Maalox-I tsp or 1 tab. p.o., repeat every 1/2 hour for 3-4 doses, if needed. Call physician for abdominal pain.
<b>Constipation</b>	Milk of Magnesia 1 oz. daily p.o. If needed more than once, obtain prn order. Do not give if abdominal pain – call physician instead.
<b>Diarrhea</b>	Clear liquid diet. Immodium 2 tsp. p.o. with each bowel movement for 3 doses, if needed.
<b>Sore Throat</b>	Salt water gargle. Tylenol 650mg q4h p.o. may also be used if needed for pain.
<b>Skin Irritation</b>	Rash –Cortaid Ointment 0.5% once. Notify physician if problem continues. Dry Skin- Vaseline Intensive Care, as per nursing discretion.
<b>Eye Irritation</b>	Irrigate eye with Dacriose Solution once. Notify physician if problem continues, or if visual problems, pain in eye or photophobia.
<b>Bee Sting</b>	Apply ice to area. For known bee sting sensitivity, there is to be a bee sting kit (Anakit/ Epi Pen) with a pharmacy patient label and instructions for use.
<b>Cuts/ Abrasions</b>	Evaluate; wash with 1/2 strength H2O2; Cover with dressing, if necessary. Arrange appropriate follow-up as needed.
<b>Burns</b>	1 <sup>st</sup> degree – apply cool H2O –medicate with Sylvadene Cream. Tylenol 650mg p.o. q4h prn pain.
<b>Shortness of Breath</b>	In emergency situations, Oxygen 2 liters per min. via nasal cannula.
<b>Skin Tears</b>	Cleanse with 1/2 strength H2O2. Apply steri strips and DSD as needed.
<b>Flu Vaccine</b>	0.5 ML IM x 1 dose. (offered annually-unless contraindicated or refused)

<p>Allergies:</p> <p>Physician's Signature: _____</p> <p>Date: _____</p>
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