PARTICIPANT ASSESSMENT

Name: ______________________________________________________ Age: _____ Assessment Date: _______

Physician: ______________________________ Allergies: ______________________________________________________

Social Environment (marital status, living arrangements, availability of friends/family/other to provide services to participant):
____________________________________________________________________________________________________
____________________________________________________________________________________________________

Economic Condition: ________________________________________________________________

Hygiene: Bathes: □ Self □ Moderate Assistance □ Total Assistance

Mouth Care: □ Self □ Moderate Assistance □ Total Assistance

Dressing: □ Independent □ Supervision □ Total Assistance

Urinary/Bowel Habits: □ Independent □ Supervision □ Wears Attends □ Urinal

Bladder Control: □ Continent □ Incontinent □ Device □ Other ____________________________

Bowel Control: □ Continent □ Incontinent □ Device □ Other _____________________________

Transferring: □ Independent □ Supervision □ Assistance □ Wheelchair to chair

Ambulation: □ Independent □ Supervision □ Assistance

Mechanical help (cane, walker) __________________________________________________________

Primary Diagnosis: ______________________________________________________________________

Secondary Diagnosis: ____________________________________________________________________

Sleeping Patterns: Night-Time ____________________________________________________________

Napping __________________________________________________________

Medications: Types of Meds Reason for Taking

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

032-05-075 (4/01)
VDSS MODEL FORM - ADCC

Nutrition: Type of Diet

Likes, Dislikes, Limitations

Appetite

Supplements

Assistance Required

Difficulties (swallowing)

Other

Mental Status/Behavior: Orientation

Problems

Aggressive, wanderer, etc.

Communication: Sight

Hearing

Speech

Able to Communicate Needs

Devices

Hobbies/ Interests: 

Additional Information:

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