Patient Name: _____ Date: _____

## NURSING ASSESSMENT

| B/P: | Pulse: | Resp: | Temp: | BG: | Ht (in): | Wt (lbs): |
|---|---|---|---|---|---|---|
| Right ABI: | | | | Left ABI: | | |

| Precautions: | | Patient Arrival: | | Departure Disposition: | | Departure Instructions: | | Special Needs: | | Point of Care Testing: | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Standard body fluid | | Ambulatory | | Without assistance | | Special needs | | Isolation | | Orthostatic | |
| MRSA | | Cane | | With assistance | | Social Services | | Emotional Patient | | Hand held Doppler | |
| VRE | | Crutches | | Transfer to: | | Simple discharge | | Educational Barrier | | Beside glucose testing | |
| HIV | | Stretcher | | Admit to: | | Complex discharge | | Language Barrier | | Specimen collection | |
| | | Wheelchair | | | | Coordination of care | | Altered Mentation | | | |

## Pain

What is the location of your pain? _____

Pain Levels: Scale used: ☐FLACC ☐FACES ☐(0-10)
Current: _____ Worst: _____ Best: _____ Acceptable: _____

Is your pain: ☐worsening ☐stable ☐improving

Is there any temporal nature to your pain? ☐occasional ☐intermittent ☐continuous

How long have you had pain? ☐3 weeks ☐3 months ☐2 weeks ☐2 months ☐1 month
☐> 3 months ☐< 1 week

Describe the quality of your pain: ☐throb ☐stabbing ☐sharp ☐prick ☐dull
☐cramping ☐burn ☐ache

What relieves or alleviates your pain? ☐relaxation ☐pharmacological ☐nothing
☐heat ☐exercise ☐distraction

What causes or increases your pain?

What parts of your life does your pain effect? ☐sleep ☐relationships ☐quality of life
☐physical activity ☐emotions ☐concentration ☐appetite

What is your current pain management regimen?

Goals for management of pain:

_____

_____

_____

## Nutrition

Unintentional weight change: ☐no change ☐loss ☐gain

Appetite change: ☐no change ☐increase ☐decrease

Difficulties preventing eating: ☐vomiting ☐taste ☐swallowing ☐purchasing food ☐nausea ☐mouth sores ☐feel full quickly ☐diarrhea ☐cooking/obtaining meals ☐constipation ☐chewing

Current diet: ☐tube feeding ☐soft mechanical ☐renal ☐regular ☐low sodium ☐low residue ☐low fat ☐liquid ☐diabetic ☐cardiac

Do you take any vitamin supplements? ☐Yes ☐No

Do you drink any meal supplement shakes? ☐Yes ☐No

Do you have any cultural, ethnic, or religious restrictions on your diet? ☐Yes ☐No

Who feeds you? ☐self ☐family member ☐care giver

Goals for Nutrition:

_____

_____

_____

_____

## Functional/Activities of Daily Living

I = Independent Mn= Minimun Md= Moderate D= Dependent

| Functional Level | Activity of Daily Living |
|---|---|
| | Ability to dress upper body |
| | Ability to dress lower body |
| | Bathing |

| Functional Level | Activity of Daily Living |
|---|---|
| | Transferring |
| | Ambulation |
| | Toileting |

## Advanced Directive

Does the patient have an Advanced Directive? ☐Yes ☐No

Would you like to share a copy with the clinic? ☐Yes ☐No

## Patient Rights

Does the patient understand their Patient's Rights? ☐Yes ☐No

Was a copy of the Patient's Rights give to the patient? ☐Yes ☐No

## Spiritual & Cultural

Does the patient have any spiritual or cultural preferences that could affect their care? ☐Yes ☐No

## Educational

Language Spoken: ☐English ☐Spanish ☐Sign ☐Other _____

Learning Preference: ☐Hearing ☐Seeing ☐Other _____

Learning Barriers: ☐Unable to read ☐Language barrier ☐Cognitive limitations ☐Hearing impairment ☐Speaking impairment ☐Visual impairment ☐Limited mobility/dexterity ☐Psychosocial factors ☐Family issues ☐Cultural practices ☐Religious practices ☐Not willing to learn ☐Not ready to learn ☐Other _____

Developmental Level: ☐Young Adult (age 18-25) ☐Adult (age 25-40) ☐Middle aged (age 41-65) ☐Old (age 66-79) ☐Frail (age 80 & older)

Learning Participants: ☐Patient ☐Family member ☐Other

## Abuse

Have you ever been emotionally or physically abuse by your partner or someone important to you?
☐Yes ☐No If yes, by whom _____ and total Number of times _____.

Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
☐Yes ☐No If yes, by whom _____ and total Number of times _____.

Within the lst year, has anyone forced you to have sexual activities? ☐Yes ☐No
If yes, by whom _____ and total Number of times _____.

Are you afraid of your partner or anyone you listed above? ☐Yes ☐No

## Personal, Family, Social History (PFSH)

Marital status: ☐single ☐married ☐divorced ☐widow

Living conditions: ☐alone ☐with family ☐nursing ☐ALF ☐SNF ☐other _____

Do you have a family or friend who can assist you with care? ☐Yes ☐No

Work history: _____ Retired because: _____

Present activity: ☐active ☐minimal ☐sedentary

Do you smoke? ☐Yes ☐No If yes, how many packs per day: ____ Year started: ____ Year stopped: ____

How long does it take to go through a six pack of beer, fifth of gin, or a bottle of wine?
☐Does not drink ☐a day ☐a week ☐a month ☐6 months ☐a year

Do you use recreational drugs? ☐Yes ☐No If yes, please list_____

Mother's cause of death: _____ Father's cause of death: _____

Other relevant family medical history:

_____

_____

_____