**YES YOU CAN HOME HELP AGENCY COMPREHENSIVE ASSESSMENT**

**SECTION 1 – CLIENT IDENTIFICATION**

|  |  |  |
| --- | --- | --- |
| Name: | Marital Status: | Address: |
| City: | State: | Zip Code: |
| Phone: | Client email: | Date of Birth: |

|  |
| --- |
| Worker Safety Issue: |

**SECTION 2 – RESIDENTIAL INFORMATION**

Person(s) in Home

|  |  |  |  |
| --- | --- | --- | --- |
| Relationship: | Name: | Concern: | Comments |
|  |  |  |  |
|  |  |  |  |

**SECTION 3 – SOCIAL RELATIONSHIPS**

What do you do for fun?

|  |  |  |
| --- | --- | --- |
| Activity: | Concern | Comments |
|  |  |  |
|  |  |  |
|  |  |  |
| Significant Life Changes | Concern |
|  |  |

**SECTION 4 – OTHER SERVICES (Circle all that apply)**

|  |
| --- |
| Community Mental Health Hospice Veteran \* Other  |
| Name and Date of last visit from Adult Protective Services Worker |

**SECTION 5 – DIAGNOSIS**

|  |  |  |
| --- | --- | --- |
| Diagnosis Description: | Diagnosis Code: | Sources/Reported By |
|  |  |  |
|  |  |  |
|  |  |  |

**SECTION 6 – HEALTH ISSUES**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Type | Concern | Comments | Type | Concern | Comments |
| Alcohol/Drugs |  |  | Sight |  |  |
| Allergies |  |  | Skin |  |  |
| Appetite |  |  | Sleeping |  |  |
| Breathing |  |  | Smoking |  |  |
| Circulation |  |  | Wandering |  |  |
| Dental |  |  | Weight |  |  |
| Diet |  |  | Other: |  |  |
| Foot Care |  |  |  |  |  |
| Hearing |  |  | Other: |  |  |
| Hygiene |  |  |  |  |  |
| MobilityOutside theresidence |  |  | Other: |  |  |

**SECTION 7– ADAPTIVE EQUIPMENT (Check if present or concern)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type** | **Present** | **Concern** | **Comments** |
| Bath Bench |  |  |  |
| Cane |  |  |  |
| Commode |  |  |  |
| CPap |  |  |  |
| Crutches |  |  |  |
| Dentures |  |  |  |
| Emergency ResponseSystem |  |  |  |
| Glasses |  |  |  |
| Grab Bars |  |  |  |
| Hand Reacher |  |  |  |
| Hearing Aid |  |  |  |
| Hoyer-Lift |  |  |  |
| Lift Chair |  |  |  |
| Motorized Scooter |  |  |  |
| Nebulizer |  |  |  |
| Oxygen |  |  |  |
| Oxygen Concentrator |  |  |  |
| Shower Seat |  |  |  |
| Special Bed |  |  |  |
| TENS |  |  |  |
| Toilet Seat Riser |  |  |  |
| Walker |  |  |  |
| Wheel Chair |  |  |  |
| Other: |  |  |  |

**SECTION 8 – WORKER OBSERVATION (Circle all that apply)**

|  |  |
| --- | --- |
| Abuse/Harm to othersAbuse/Harm to selfAnxietyDepressionDisorientationFamily StressFinancial StressInadequate Care of SelfInappropriate Sexual GesturesInappropriate Sexual Speech | Memory impairmentSeeks inappropriate attentionSmokes CarelesslyStalkingSubstance AbuseWandersOther |

I authorize Yes You Can Home Help Agency, LLC to conduct chore services and provide services and resources.

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Client Name Date