Arizona State Veteran Home

Functional Assessment

Applicant's Name:_____ Date: _____

Date of Birth:_____ Current Living Arrangements:_____

_____

Person completing This Form:_____ Relationship to Applicant_____

Applicant's Medical Diagnoses:_____

_____

For each area of functioning listed below, please describe to the best of your ability the amount and type of assistance the applicant requires.

BATHING

Does applicant take a shower, tub bath or sponge bath?_____

How often does he/she bathe?_____

How much assistance is needed?_____

DRESSING

How much assistance does applicant receive in dressing (including selecting and getting clothes from closet, putting on undergarments and using fasteners)?_____

_____

_____

Additional Comments_____

_____

_____

TOILETING

Does applicant require assistance with toileting (including getting to and from bathroom, cleaning self after elimination and arranging clothes)?_____

If yes, how much assistance is needed?_____

_____

Does applicant have a catheter? What type?_____

Does he/she have a colostomy?_____

Is applicant able to control urination?_____ Bowel movements?_____

If no, how often do "accidents" occur?_____

MOBILITY

Does applicant walk (list assistive devices used, i.e., walker, cane) or does he/she use a wheelchair?_____

Does he/she need assistance getting out of bed or a chair?_____

If yes, how much assistance is needed?_____

_____

EATING

Does applicant feed self or require assistance eating?_____

_____

Does he/she use adaptive equipment while eating (i.e., plate guard, special spoon, etc.)?_____

Is he/she on a special diet?_____

How would you describe applicant's appetite?_____

Height_____ Weight_____

MEDICATION

List applicant's current medications:_____

_____

_____

Any known drug allergies?_____

_____

Is applicant using oxygen (if yes, how much and how often)?_____

_____

PROSTHESES

Does applicant have an arm or leg prosthesis?_____

Does he/she wear dentures (upper and lower)?_____

Does he/she use a hearing aide?_____

SKIN

Does applicant presently have bed sores (if yes, where and for how long)?_____

_____

Does he/she have skin rashes?_____

Does he/she experience swelling of the legs or feet?_____

_____

ORIENTATION

Is applicant alert and oriented or does he/she exhibit confusion? (If confused, is it ongoing, often, or occasional?)_____

_____

_____

For individuals who are confused and disoriented:

Does the applicant attempt to wander?_____

If yes, how often?_____

Is he or she willing to return if given direction?_____

OTHER HEALTH CONSIDERATIONS

Does applicant currently use physical or chemical restraints? If yes, describe type and frequency:_____

_____

Has he/she ever been hospitalized for mental health problems? If yes, state when, where, and why:_____

_____

Does applicant maintain active and satisfying relationships with family and friends?_____

_____

Does he/she have a history of drug or alcohol abuse? If yes, please describe:___

_____

_____

Is applicant a smoker? _____ If yes, is he considered a safe smoker? _____

Is applicant currently receiving physical, occupational, speech, or respiratory therapy? If yes, list type of therapy, reason for, and frequency received:_____

_____

_____

Additional Comments:_____

_____

_____

_____