Longview

Longview Social Adult Day Program

Functional Assessment Form

Participant Profile

Name ______________________________ Phone _________________

Address ____________________________ D.O.B. ______________
____________________________ Sex _____
____________________________ Race ___________________

Religious Preference ____________ Living Arrangements _____________
Marital Status _________________ _____________

Family Members at Home:
Name: Relationship:
______________________________ _________________________
______________________________ _________________________
______________________________ _________________________

Past Work Experience:
____
____

Educational Background: ____
Special Skills/ Interests:
____
____

Social Resources/ Needs

Family members with whom participant has supportive relationship:
____

Family members living nearby: ___________________________________

Frequency of contacts: By phone________ Visits to participant ___________

Participants makes visits ___________

Neighbors/ Friends who are supportive:

____

____

Social/ Conversational skills:
Initiates/ engages in conversation: ____

Maintains social contacts: Neighbors ________ Church __________
Friends ________ Other __________________

Seeks needed help or assistance:
Assistance requested: _______________________ From: ________________________

Has someone to confide in (Name): ____

Has someone who will provide necessary help in event of sickness (Name)

____

Has meaningful role in family ________________ Neighbor _____________
Social group ________________ Church ______________
Other ____

Social support system appears:
____ Very Supportive
____ Adequate
____ Inadequate
____ No social support system

Interviewer's comments:

____

____

____

Social needs:

____

____

Physical Resources/ Needs

Ambulation: Walks without assistance: ___________________

Needs help with:
____ Stairs
____ Carpeted floors
____ Uneven terrain

Walks with assistance of: ____ Tripod
____ Cane ____ Wheelchair
____ Walker ____ Support of another person

Any paralysis: ______________________ What part of body: _____________________
Any difficulty with motor control: ____
Any sensory loss: _____________ Describe: ___________________________________

Any speech impediment/ aphasia: ____

Any loss of bowel/ kidney control: ____

Condition of teeth and gums: ____

Weight problem: _______________ Evidence of malnutrition: ______________

Therapeutic diet: ____

Acute health problems: ____

Chronic health problems: ____

Prescribed medications: For:

_____________________________________ ______________________________
_____________________________________ ______________________________
_____________________________________ ______________________________
_____________________________________ ______________________________
_____________________________________ ______________________________

Non-prescription drugs: For:

_____________________________________ ______________________________
_____________________________________ ______________________________
_____________________________________ ______________________________
_____________________________________ ______________________________
_____________________________________ ______________________________

Can take own medication: _______________ Needs supervision: ______________

Medications must be administered: ____

Any history of alcoholism: ____
Other substance addiction: ____

Days of illness during last six months (unable to carry out normal activities): __________

Number of days spent in hospital/nursing home/rest home in last six months: __________

Able to participate in physical activities: ____ Walking
____ Swimming
____ Exercise sessions
____ Outside games

Any prescribed therapy or activity: ____

Any supportive devices being used:

____ Leg brace	____ Artificial limb	____ Hearing aid
____ Glasses	____ Contact lenses	____ Dentures
____ Catheter	____ Kidney dialysis	____ Colostomy equipment

Other: ____

Any special instructions/ assistance needed with these: ____________________________

Interviewer's comments:

____

____

Needs not presently being met:

____

____

Mental/ Emotional Resources and Needs

Any diagnosed mental/ emotional illness or problem:

____

____

Any observed indications/symptoms of mental/emotional disorders:

____ Depression	____ Anxiety	____ Withdrawal
____ Paranoia	____ Hypochondria	____ Confusion
____ Disorientation	____ Memory loss	____ Sense of uselessness
____ Hallucinations	____ Acting out	____ Aggressive behavior
____ Sexual fixation	____ Hostility	____ Self-neglect/ abuse
____ Anger	____ Wandering	____Other

Describe symptoms:

____

____

____

Able to express self verbally: __________ Exhibits understanding of others: __________

Appears able to make decisions: __________

Exhibits evidence of: ____ Independence ____Dependence
Describe:
____
____

Evidence of self-motivation: ____
Appears to maintain healthy relationships: _______________________

Copes well with others: ______________________________________

Manages personal affairs: ________ Another person manages affairs: _______

Shows common sense in making judgements: _________________________________

Exhibits ability to adapt to new circumstances and situations: ______________________

Demonstrates ability to adjust to any loss of function/ change in roles: _______________

Finds use for leisure time: ______ List activities: ______________________________
____
____

Interviewer's comments:
____
____

Needs not presently being met:
____
____

ADL/IADL Resources and Needs

Cares for personal grooming:
____ Well
____ Adequately
____ Inadequately
____ Has help (Describe: ____________________)
____ Grooming not cared for

Is able to care for personal needs (Insert code below: 1= Without assistance, 2= Supervision is needed, 3= Assistance of equipment, 4= Assistance of a person, 5= Assistance of equipment and a person, 6= Unable to accomplish, 7= not observed):

Item	Code	Comments
1. Eating	_______	______________________________
2. Meal preparation	_______	______________________________
3. Toileting	_______	______________________________
4. Dressing/Undressing	_______	______________________________
5. Bathing	_______	______________________________
6. Getting in and out of bed	_______	______________________________
7. Household chores	_______	______________________________
8. Shopping	_______	______________________________
9. Laundry	_______	______________________________
10. Manages finances	_______	______________________________
11. Manages household	_______	______________________________
12. Takes own medications	_______	______________________________
13. Uses public transportation	_______	______________________________
14. Uses telephone	_______	______________________________

Signature ____ Date: _____________

Position: ____

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