Client In-Home Evaluation

General Information

Date of Assessment	Assessment date
Person Completing Assessment	MHP name
Client Name	Client name
Client D.O.B	D.O.B.
Client Social Security Number	SS number
Contact Information (Verify) A. Address B. Phone Number C. Alternate Phone Number	Client contact information
Emergency Contact(s) A. Name B. Relationship C. Phone Number	Emergency contact information
Assessment Type	☐Start of Care ☐Resumption of Care ☐Discharge from Care

Physical Environment

Living Arrangement	
Residence Type	☐ Primary (home/apartment – alone or with others) ☐ Secondary ☐ Group Home ☐ Halfway House ☐ Independent Living ☐ Assisted Living: Facility name ☐ Nursing Home: Facility name ☐ Homeless (Shelter, Drop-in Facility, Street)
Living Situation	☐ Lives Alone ☐ Lives with spouse or significant other ☐ Lives with another family member or friend ☐ Lives with unrelated caregiver ☐ Lives in Congregate Situation ☐ Group Home ☐ Assisted Living ☐ Nursing Home
Cleanliness of Environment [if unlivable please be specific in documentation of reason(s)]	☐ Unlivable (hoarding, multiple infestations, mold, mildew, feces, urine, etc.) ☐ Unclean / Disheveled (not organized, but not unhealthy) ☐ Average (not affecting ADL's) ☐ Clean / Tidy / Organized

Sanitation Issues	
Is there any clutter in the living space which may present a fire or other danger?	☐ Yes ☐ No
Are there trash issues, insects, or rodents present?	☐ Yes ☐ No
Is there a functioning indoor toilet space?	☐ Yes ☐ No
Is running water available in the residence?	☐ Yes ☐ No
Food	
Do you have enough food on most days?	☐ Yes ☐ No
Do you have a way to store food safely?	☐ Yes ☐ No
Do you have a way to cook food properly?	☐ Yes ☐ No
Environment Risk Assessment	
Are there barriers in the residence which pose trip hazards, other hazards, or safety risks?	☐ Yes ☐ No
Does the residence have adequate lighting for safe navigation?	☐ Yes ☐ No
Is heating and/or cooling of the residence available as needed?	☐ Yes ☐ No
Is there a smoke detector present and functioning properly?	☐ Yes ☐ No
Is there a carbon monoxide detector present and functioning properly?	☐ Yes ☐ No
Is there consistent access to a working telephone?	☐ Yes ☐ No
Is there an available kitchen which is functioning properly and safely?	☐ Yes ☐ No

Fall Risk Assessment	
Have you had a fall or near fall in the past?	☐ Yes ☐ No
Do you have a fear of falling?	☐ Yes ☐ No
Do you have difficulty standing from a sitting position?	☐ Yes ☐ No
Do you take your time getting up to answer the phone or doorbell?	☐ Yes ☐ No
Do you exercise regularly?	☐ Yes ☐ No
Do you use a walker, cane, or anything else to get around?	☐ Yes ☐ No
Do you wear sturdy, well-fitting, low heeled shoes with non-slip soles?	☐ Yes ☐ No
Is your carpeting in good condition?	☐ Yes ☐ No
Do you keep walking areas and stairways clear of tripping hazards, such as papers, books, electrical cords, shoes, and oxygen tubing?	☐ Yes ☐ No
Do you wipe up spilled liquids right away?	☐ Yes ☐ No
Do your rugs have rubber, non-skid backing?	☐ Yes ☐ No
Are there non-slip mats in and outside bathtubs and showers?	☐ Yes ☐ No
Do you have grab bars in tubs, showers, and near all toilets?	☐ Yes ☐ No
Are there sturdy, easy-to-grip-handrails on both sides of the stairs?	☐ Yes ☐ No
Do you have nightlights along the path between your bedroom and the bathroom?	☐ Yes ☐ No
Does every room have a light switch that can be reached from the doorway?	☐ Yes ☐ No

Do you turn on the lights before using the stairs?	☐ Yes ☐ No
Do you have pets that move freely in the house?	☐ Yes ☐ No
Do you take four (4) or more prescription medications?	☐ Yes ☐ No
Do you take any medications which affect your balance or coordination?	☐ Yes ☐ No
Have you contacted your doctor or pharmacist if your medication affects your balance and/or coordination?	☐ Yes ☐ No

Social Environment / Social Support

Abuse / Neglect / Exploitation	
Is there a previous history of abuse, neglect, and/or exploitation?	☐ No ☐ Abuse (mental, emotional, physical, or sexual injury to a child or person 65 years or older or an adult with disabilities or failure to prevent such injury) ☐ Neglect (Neglect of a person 65 years or older or an adult with disabilities that results in starvation, dehydration, over- or under-medication, unsanitary living conditions, and lack of heat, running water, electricity, medical care, and personal hygiene. Neglect of a child includes failure to provide a child with food, clothing, shelter and/or medical care; and/or leaving a child in a situation where the child is at risk of harm. ☐ Exploitation (misusing the resources of a person 65 years or older or an adult with disabilities for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.
Do you feel safe at home?	☐ Yes ☐ No: Reasons
Is there anyone harming you or threatening to harm you?	☐ Yes: How are you being harmed? ☐ No
Do you have social support available? (check all that apply)	☐ Family ☐ Friends ☐ Religious organization ☐ Social group – other: Social group ☐ Veteran Affairs ☐ No social support available

Economic Resources

Health Insurance / Funding	
What type of health insurance / funding do you have?	☐ Private pay / Unfunded ☐ Private Insurance: Insurance carrier ☐ Medicare ☐ Medicaid ☐ JPS Connection ☐ VA Benefits ☐ Other: Other funding source
Monetary Resources	
Are you having any trouble paying rent?	☐ Yes ☐ No
Are you having any trouble paying for your utilities?	☐ Yes ☐ Electric (provider): Electric provider ☐ Water (provider): Water provider ☐ Gas (provider): Gas provider ☐ Telephone (provider): Telephone provider ☐ No

Transportation

Do you have reliable transportation?	☐ Yes ☐ No
What is your main source of transportation?	☐ Personal Vehicle ☐ Friend or Relative ☐ Taxi ☐ Bus ☐ Bicycle ☐ Walking

Health Information

Physical Health	
How would you rate your overall physical health? (pick one)	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
What medical conditions have you been diagnosed with?	☐ Cancer: Cancers ☐ Cardiac/Heart : Heart disease ☐ EENT: EENT problems ☐ GI/GU : GI/GU problems ☐ Hematology/Infectious Disease: Hematology/Infectious diseases ☐ Metabolic/Endocrine: Metabolic/Endocrine disorders ☐ Neurological/Brain: Neuro disorders ☐ OB/GYN: OB/GYN problems ☐ Respiratory/Lungs: Respiratory problems ☐ Musculoskeletal/Connective Tissue: Musculoskeletal disorders ☐ Surgical History: Surgical history ☐ Other: Other medical problems ☐ None
Family History (please include relationship to patient)	☐ None ☐ Other: Family history

Tobacco/Alcohol/Drug Use	
Do you currently smoke tobacco products?	☐ Yes ☐ How long have you smoked? Enter number (years) ☐ How many cigarettes do you smoke daily? Enter number ☐ No ☐ Did you smoke in the past? ☐ Yes ☐ When did you quit? Date ☐No
Do you currently drink alcohol?	☐ Yes ☐ How often do you drink? Choose an item ☐ How much do you drink? Amount of alcohol consumed ☐ No ☐ Do you have a previous history of alcohol use? ☐ Yes ☐ When did you stop drinking? Date ☐ No
Do you currently use any illicit drugs?	☐ Yes ☐ What drugs do you currently use? Current drugs used ☐ How often do you use them? Choose an item ☐ No
Would you like us to provide you with information on resources to change your current habits?	☐ Yes ☐ No

Mental Health	
Have you ever been diagnosed with any mental health disorders?	☐ Yes: Mental health history ☐ No
Do you currently work with MHMR?	☐ Yes ☐ Case Manager: Case manager name ☐ Case Manager Contact Information: Contact information ☐ No ☐ Have you worked with MHMR in the past? ☐ Yes ☐ No
Do you currently meet with a therapist regularly?	☐ Yes: Therapist information ☐ No
Do you currently have a case manager or service coordinator (outside of MHMR)?	☐ Yes ☐ Case Manager: Case manager information ☐ Case Manager Contact Information: Case manager information ☐ No

Depression Screening Tool	
• *Answers indicating depression are highlighted.* • *Each highlighted answer counts as one point.* • *Four to nine points indicates a probability of depression existing* • *Ten or more points is almost always indicative of depression existing.*	
Are you basically satisfied with your life?	☐ Yes ☐ No
Have you dropped many of your activities and interests?	☐ Yes ☐ No
Do you feel that your life is empty?	☐ Yes ☐ No
Do you often get bored?	☐ Yes ☐ No
Are you in good spirits most of the time?	☐ Yes ☐ No
Are you afraid that something bad is going to happen to you?	☐ Yes ☐ No
Do you feel happy most of the time?	☐ Yes ☐ No
Do you often feel helpless?	☐ Yes ☐ No
Do you prefer to stay at home, rather than going out and doing new things?	☐ Yes ☐ No
Do you feel you have more problems with memory than most?	☐ Yes ☐ No
Do you think it is wonderful to be alive now?	☐ Yes ☐ No
Do you feel pretty worthless the way you are now?	☐ Yes ☐ No
Do you feel full of energy?	☐ Yes ☐ No
Do you feel your situation is hopeless?	☐ Yes ☐ No
Do you think most people are better off than you?	☐ Yes ☐ No
Total Points	Total points

Disease Process Education/Understanding/Management	
Can you tell me what you understand about how each of your diseases affects you?	Disease process understanding
Are you having any problems managing any of your disease processes?	☐ Yes: Which processes? ☐ No
Does the client have good understanding of their disease processes?	☐ Yes ☐ No: Which processes?
Is the client adequately managing all their disease processes?	☐ Yes ☐ No: Which processes?
Medication History	
Medication inventory performed?	☐ Yes ☐ No
Do you have any problems acquiring medications?	☐ Yes ☐ Funding ☐ Pickup ☐ Other: Other medication problems ☐ No
Do you have any problems taking your medication as prescribed?	☐Yes ☐ Organization ☐ Forgetting ☐ Unable to swallow large pills ☐ Other: Other medication problems ☐ No
Physician Information	
Do you currently have a primary care physician?	☐ Yes: PCP information ☐ No
Do you currently see any specialist(s)?	☐ Yes: Specialist(s) information ☐ No
When was the last time you saw your physician?	☐ PCP: Date ☐ Specialist: Date
How often do you see your physician?	☐ PCP: Frequency ☐ Specialist: Frequency

Hospital Use	
Have you been to the emergency room in the last year?	☐ Yes ☐ Number of visits: Number of visits ☐ Visit reasons: Visit reasons ☐ No
Have you been admitted into the hospital in the last year?	☐Yes ☐ Number of admissions: Number of admissions ☐ Admission reasons: Admission reasons ☐ No
EMS Use	
Have you called 911 for an ambulance in the last year?	☐ Yes ☐ Number of times: Number of calls ☐ Reasons for calls for service: Call reasons ☐ No

AMR MOBILE INTEGRATED HEALTHCARE

Daily Living/Impairment Assessment			
• *0 = No Impairment – No functional impairment. The individual is able to conduct activities without difficulty and has no need for assistance.* • *1 = Mild Impairment – Minimal or mild functional impairment. The individual is able to conduct activities with minimal difficulty and needs minimal assistance.* • *2 = Severe Impairment– Extensive and severe functional impairment. The individual has extensive difficulty carrying out activities and needs extensive assistance.* • *3 = Total Functional Impairment – The individual is unable to carry out any part of the activity.*			
ADL/IADL	**Score**	**Assistance Available (if needed)**	**Comment**
Cleaning house	Score	☐ Yes ☐ No	Comment
Do own laundry	Score	☐ Yes ☐ No	Comment
Getting in/out of bed or chair	Score	☐ Yes ☐ No	Comment
Bathing/Showering	Score	☐ Yes ☐ No	Comment
Getting to bathroom/Using toilet	Score	☐ Yes ☐ No	Comment
Trouble cleaning after toilet use	Score	☐ Yes ☐ No	Comment
Walking	Score	☐ Yes ☐ No	Comment
Transfers	Score	☐ Yes ☐ No	Comment
Opening cans/jars/bottles	Score	☐ Yes ☐ No	Comment
Preparing meals/Cooking	Score	☐ Yes ☐ No	Comment
Eating/Feeding self	Score	☐ Yes ☐ No	Comment
Dressing	Score	☐ Yes ☐ No	Comment

Grooming (shave, brush your teeth, shampoo and comb your hair)	Score	☐ Yes ☐ No	Comment
Shopping	Score	☐ Yes ☐ No	Comment
Using telephone	Score	☐ Yes ☐ No	Comment
Take own medication	Score	☐ Yes ☐ No	Comment
Total Score	Total		Comment
Adaptive Equipment Used	Adaptive equipment information		
ADL/IADL Comments	ADL/IADL comments		

Summary

Identified Needs	
Program Identified	Click here to enter text
Client Identified	Click here to enter text
Goals	
Program Identified	Click here to enter text
Client Identified	Click here to enter text
Plan	
Program Identified	Click here to enter text
Client Identified	Click here to enter text

Notes

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References

"Fort Worth Fire Home Safety Evaluation Checklist." *Fort Worth Safe Communities Coalition*. Web. 01 Aug. 2014. <http://www.fwscc.org/?page_id=2133>.

Texas. Texas Department of Aging and Disability Services. *Form 2060 – Needs Assessment Questionnaire and Task/Hour Guide*. July 2012. Web. 01 Aug. 2014. <http://www.dads.state.tx.us/forms/2060/>.

Yesavage, JA. *Geriatric Depression Scale*. Stanford / VA / NIA Aging Clinical Research Center, N.d. Web. 01 Aug. 2014. <http://web.stanford.edu/~yesavage/GDS.html>.