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Client: **Page:** **of:**

Location: H = Home ☐ Hp = Hospital ☐ O = Office ☐ DO = Doctor's office ☐ OTH = Other ☐
Contact: I=In person ☐ P=Phone ☐ L=Letter ☐ F=Fax ☐ C=Card ☐ EM=E-Mail ☐
General Health: E = Excellent ☐ G = Good ☐ P = Poor ☐ FR = Frail ☐
Ambulation: Independent ☐ Cane ☐ Walker ☐ Wheelchair ☐ Bedridden ☐

Appetite ☐ excellent ☐ good ☐ poor ☐ eats independently ☐ needs to be fed
Bowel and bladder ☐ continent ☐ incontinent of ☐ bowel ☐ bladder ☐ both (B and B)
Cognitive ability
Communication ability
Eyes ☐ glasses needed (reading/distance/TV) ☐ not needed
Hearing ☐ hearing aid (right ear/left ear/both) ☐ not needed
Skin ☐ excellent ☐ breakdown ☐ location _____
Sleep: ☐ full night ☐ wakes occasionally ☐ wakes often ☐ naps ☐ hardly sleeps ☐ wanders
Teeth and gums ☐ own teeth ☐ partial dentures ☐ full dentures ☐ gums

Problems/concerns
New medications (date / /) for _____
Delete medications (date / /) for _____
Next medical appointment (date / /) or procedure ☐ with _____
location _____
Items to be ordered: phone _____
fax _____
_____
_____

Time (am/pm) date/day location	Agenda/Activity	Disbursements Expense/Cost Needs

☐ see over ➔