

**Hannah & Friends Resident Assessment Form**

Date: \_\_\_\_\_

Resident's Name: \_\_\_\_\_ Date of Birth : \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone \_\_\_\_\_

**Are you currently receiving waiver services?**      YES      NO

If YES, which waiver?      DD      SSW      TBI      AUTISM

Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

**Address of Assessment:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Resident History**

Social History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Educational/Vocational History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mental Health History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Social Supports: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Functional Assessment**

Medical Needs List:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Current Medications (Name, dose and purpose)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Hospitalization/Surgery History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special diet: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Equipment or Therapy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sensory/Expressive Impairment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Auditory: \_\_\_\_\_  
\_\_\_\_\_

Visual: \_\_\_\_\_  
\_\_\_\_\_

Speech: \_\_\_\_\_  
\_\_\_\_\_

**Functional Capabilities:**

Control of bowel and bladder: \_\_\_\_\_

Management of toileting at night: \_\_\_\_\_

Bathing: \_\_\_\_\_

Transferring bed, chair, toilet, etc.: \_\_\_\_\_

Dressing: \_\_\_\_\_

Eating: \_\_\_\_\_

Meal preparation: \_\_\_\_\_

Functional Capabilities: (cont.)

Shopping: \_\_\_\_\_

Mobility: \_\_\_\_\_

Driving: \_\_\_\_\_

Assistive Devices: \_\_\_\_\_

Taking Medication: \_\_\_\_\_

Reaching light switches: \_\_\_\_\_

Home security: \_\_\_\_\_

Ability to use phone: \_\_\_\_\_

Housekeeping, laundry: \_\_\_\_\_

Managing home repairs: \_\_\_\_\_

Money management: \_\_\_\_\_

Ability to respond in emergency: \_\_\_\_\_

Home Safety Assessment:

Carpeting and rugs: \_\_\_\_\_

Exposed pipes, radiators, cords: \_\_\_\_\_

Bath tub safety devices: \_\_\_\_\_

Adequate lighting: \_\_\_\_\_

Flooring: \_\_\_\_\_

Fire hazards: \_\_\_\_\_

Furniture: \_\_\_\_\_

Cane/walker safety: \_\_\_\_\_

Railings/grab bars: \_\_\_\_\_

Smoke alarms: \_\_\_\_\_

Posted emergency number: \_\_\_\_\_

Stove/cooking safety: \_\_\_\_\_

Access in/out of house: \_\_\_\_\_

**Cognitive Function**

Orientation: \_\_\_\_\_

Short term memory: \_\_\_\_\_

Long term memory: \_\_\_\_\_

Language skills: \_\_\_\_\_

Visual/spatial skills: \_\_\_\_\_

Reasoning/Judgment: \_\_\_\_\_

Insight: \_\_\_\_\_

Executive Function: \_\_\_\_\_

Motor Skills: \_\_\_\_\_

**Psychological Function**

Presentation/Appearance: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Mood/Affect: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Anxiety: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Psychological

Delusions: \_\_\_\_\_

\_\_\_\_\_

Hallucinations: \_\_\_\_\_

\_\_\_\_\_

Agitation: \_\_\_\_\_

\_\_\_\_\_

Behavioral Disturbance: \_\_\_\_\_

\_\_\_\_\_

Summary of Findings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of person completing form \_\_\_\_\_ Date \_\_\_\_\_