

Resident Individual Assessment – AASC Online

| | | | |
|---|---|---|---|
| Personal Data | | Date of Assessment: ____/____/____ | |
| Resident Name: | | Unit No: | |
| Medical Exam | | | |
| Has the resident received a routine medical examination by a health care provider in the past 12 months? | | | |
| <input type="checkbox"/> Yes If yes, date of last routine medical examination by a health care provider [Month _____ Year _____] _ <input type="checkbox"/> No <input type="checkbox"/> Resident does not know <input type="checkbox"/> Resident refused | | | |
| Dental Exam | | | |
| Has the resident received a routine dental examination in the past 12 months? | | | |
| <input type="checkbox"/> Yes If yes, date of last routine medical examination by a health care provider [Month _____ Year _____] _ <input type="checkbox"/> No <input type="checkbox"/> Resident does not know <input type="checkbox"/> Resident refused | | | |
| Personal Functioning | | | |
| Personal Development: Do you observe the resident displaying any of these behaviors? | | | |
| <input type="checkbox"/> Active | <input type="checkbox"/> Wants company | <input type="checkbox"/> Has limited support | |
| <input type="checkbox"/> Has been active | <input type="checkbox"/> Wants friendship | <input type="checkbox"/> Never leaves home | |
| <input type="checkbox"/> Wants to be active | <input type="checkbox"/> Wants to volunteer | <input type="checkbox"/> Has experienced a loss | |
| <input type="checkbox"/> Wants work | | | |
| Notes/Comments: | | | |
| | | | |
| Behaviors Observed | | | |
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Feels hopeless | <input type="checkbox"/> Tearful | |
| <input type="checkbox"/> Pleasant | <input type="checkbox"/> Complains of threats | <input type="checkbox"/> Suspicious | |
| <input type="checkbox"/> Responsive | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Angry | |
| <input type="checkbox"/> Monotone speech | <input type="checkbox"/> Hallucinates | <input type="checkbox"/> Anxious | |
| <input type="checkbox"/> Difficulty in speech | <input type="checkbox"/> Afraid | | |
| Socialization | | | |
| Hobbies/Talent (Past or Present): | | | |
| Activities/Groups (Past or Present): | | | |
| How does the Resident typically spend a day? | | | |
| Notes/Comments: | | | |
| | | | |
| Emotional Status | | | |
| Does the resident state or imply any of these behaviors? | | | |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Suicidal behavior | <input type="checkbox"/> Worry/Anxiety |
| <input type="checkbox"/> Easily upset | <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Suicidal talk | <input type="checkbox"/> Medication abuse |
| Is the emotional status typical of resident's lifelong emotional pattern, or just recent? <input type="checkbox"/> Lifelong <input type="checkbox"/> Recent | | | |
| Currently or ever received professional help/counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Does resident acknowledge need for assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Is the resident currently being treated for substance abuse or dependence, or have they been treated in the past 12 months? | | | |

- Yes, the resident is currently being treated for substance abuse
- The resident is not currently being treated for substance abuse or dependence but did receive treatment in the past.
Estimated date of last treatment [Month _____ Year _____]
- The resident has never been treated for substance abuse or dependence
- Resident does not know
- Resident refused

Community Supports

Family and Friends Support and Involvement

Client has family and/or friends

- | | | |
|---|---|--|
| <input type="checkbox"/> Who call regularly | <input type="checkbox"/> Assist sometimes | <input type="checkbox"/> Resident refuses help |
| <input type="checkbox"/> Visit regularly | <input type="checkbox"/> Assist, but stressed | <input type="checkbox"/> Does not need help |
| <input type="checkbox"/> Assist with care | <input type="checkbox"/> Have no family | <input type="checkbox"/> Resident is satisfied |

Agency/Family/Friend Involvement

Name: _____ Frequency: _____ Service Provided: _____

Name: _____ Frequency: _____ Service Provided: _____

Name: _____ Frequency: _____ Service Provided: _____

Transportation

Has Transportation? Yes No Transportation Adequately Meets Resident's Needs? Yes No

Needs Transportation? Yes No Has Vehicle / Access To A Vehicle? Yes No

Has Driver's License? Yes No

Notes/Comments:

Mental Functioning (Based on professional observation)

- | | |
|------------------------|--|
| Alertness/Orientation: | <input type="checkbox"/> Disoriented <input type="checkbox"/> Memory impaired <input type="checkbox"/> Wanders <input type="checkbox"/> Forgetful <input type="checkbox"/> Confused <input type="checkbox"/> Flight of ideas <input type="checkbox"/> Delayed reaction |
| Time: | |
| Place: | |
| Person: | |
| | |

Appearance:

- | | | | | |
|-------------------------|--|--|--|--|
| Clothing: | <input type="checkbox"/> Inappropriate | <input type="checkbox"/> Appropriate | <input type="checkbox"/> Not fully clothed | <input type="checkbox"/> Multilayer |
| Grooming: | <input type="checkbox"/> Not clean | <input type="checkbox"/> Unshaven | <input type="checkbox"/> Body-urine odor | <input type="checkbox"/> Satisfactory |
| Alcohol/Drugs: | <input type="checkbox"/> Slurred speech | <input type="checkbox"/> Staggers | <input type="checkbox"/> Alcohol smell | <input type="checkbox"/> Empty bottles |
| Signs of poor judgment: | <input type="checkbox"/> Strangers in home | <input type="checkbox"/> Gives away \$ | <input type="checkbox"/> Lets nobody in home | <input type="checkbox"/> Appropriate |

Notes/Comments

