LEND A HAND COMPANION CARE SERVICES, LLC
CLIENT ASSESSMENT SHEET

NAME: ____

ADDRESS:____

PHONE: ____________________________ EMAIL: _________________________

DOB______ HEIGHT______ WEIGHT______ ALLERGIES______ DNR/PROXY ______

NEUROLOGICAL:

Stroke Yes___ No___

Awake alert oriented to time and place	Yes___ No___
Any difficulty with swallowing	Yes___ No___
Unsteady Gait	Yes___ No___

LUNGS:

COPD	Yes___ No___
Home Oxygen	Yes___ No___

CARDIAC:

HTN	Yes___ No___
Heart Attack	Yes___ No___
Arrhythmia	Yes___ No___
Pacemaker/Defibrillator	Yes___ No___

GASTROINTESTINAL / URINARY:

Poor Appetite	Yes___ No___
Dentures / Loose Teeth	Yes___ No___
Incontinent	Yes___ No___

MOBILITY:
Cane or Walker Yes___ No___

Personal Care / Dressing Yes___ No___

Diabetic Yes___ No___

CONTACT PERSON:

NAME: ____

ADDRESS:____

PHONE: ________________________ EMAIL: _________________________

ADDITIONAL NOTES