# Initial Patient Assessment

**Date:**

**Time:**

## NUTRITION RISK SCREEN: Circle the number in the “Yes” column for those that apply to the patient.  

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total nutritional score at the bottom. Patient assessed initially and at least every three months. (Nurse to frame these as questions to patient)</td>
<td></td>
</tr>
<tr>
<td>I have an illness or condition that made me change the kind and/or amount of food I eat</td>
<td>2</td>
</tr>
<tr>
<td>I eat fewer than two meals per day</td>
<td>3</td>
</tr>
<tr>
<td>I eat few fruits and vegetables, or milk products</td>
<td>2</td>
</tr>
<tr>
<td>I have three or more drinks of beer, liquor or wine almost every day</td>
<td>2</td>
</tr>
<tr>
<td>I have tooth or mouth problems that make it hard for me to eat</td>
<td>2</td>
</tr>
<tr>
<td>I don’t always have enough money to buy the food I need</td>
<td>4</td>
</tr>
<tr>
<td>I eat alone most of the time</td>
<td>1</td>
</tr>
<tr>
<td>I take three or more different prescribed or over-the-counter drugs a day</td>
<td>1</td>
</tr>
<tr>
<td>Without wanting to, I have lost or gained 10 pounds in the last six months</td>
<td>2</td>
</tr>
<tr>
<td>I am not always physically able to shop, cook and/or feed myself</td>
<td>2</td>
</tr>
</tbody>
</table>

Total Score:__

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**ABUSE/SUICIDE RISK SCREEN:** Check the appropriate answer for each question. (Nurse to ask patient questions 1-4 when patient is alone.)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has anyone close to you tried to hurt or harm you recently?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you feel uncomfortable with anyone in your family?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Has anyone forced you to do things that you didn’t want to do?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Do you have any thoughts of harming yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Patient displays signs or symptoms of abuse and/or neglect.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes to any of the above questions, explain:

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**FALLS RISK SCREEN:** Circle the appropriate score for each question. Total the score at the bottom of this section.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of falling - immediate or within 3 months</td>
<td>25</td>
</tr>
<tr>
<td>2. Secondary diagnosis</td>
<td>15</td>
</tr>
<tr>
<td>3. Ambulatory aid</td>
<td>0</td>
</tr>
<tr>
<td>Crutches/cane/walker</td>
<td>15</td>
</tr>
<tr>
<td>Furniture</td>
<td>30</td>
</tr>
<tr>
<td>4. IV Access / Saline Lock</td>
<td>20</td>
</tr>
<tr>
<td>5. Gait/Transferring</td>
<td>0</td>
</tr>
<tr>
<td>(Only applicable if any “Yes” answers in 1 - 4)</td>
<td></td>
</tr>
<tr>
<td>Normal/ bed rest/immobile</td>
<td>10</td>
</tr>
<tr>
<td>Weak</td>
<td>20</td>
</tr>
<tr>
<td>Impaired</td>
<td>20</td>
</tr>
<tr>
<td>6. Mental status</td>
<td>0</td>
</tr>
<tr>
<td>(Only applicable if any “Yes” answers in 1 - 4)</td>
<td></td>
</tr>
<tr>
<td>Oriented to own ability</td>
<td>15</td>
</tr>
<tr>
<td>Overestimates or forgets limitations</td>
<td></td>
</tr>
</tbody>
</table>

Total Score:__

---

**Fall Risk Scale and Risk Level** (Interventions are documented in the care plan)

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 24 = Low Risk</td>
<td>25 – 50 = Medium Risk</td>
</tr>
</tbody>
</table>

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Nurse Signature:__ Date:__ Time:__
### Initial Patient Assessment

#### Date:  

#### Time:  

**PAIN ASSESSMENT**

- **Pain present now?**
  - [ ] Yes
  - [ ] No
  - If NO, skip rest of this section. **Non-wound related pain referred to primary care provider**

- **With Dressing Changes:**
  - [ ] Yes
  - [ ] No

- **Location of Pain:**

- **Current Pain Level:**
  - [ ] Insensate
  - [ ] 0
  - [ ] 1
  - [ ] 2
  - [ ] 3
  - [ ] 4
  - [ ] 5
  - [ ] 6
  - [ ] 7
  - [ ] 8
  - [ ] 9
  - [ ] 10

- **Duration of Pain:**
  - [ ] Constant
  - [ ] Intermittent

- **Character of Pain:**
  - [ ] Aching
  - [ ] Burning
  - [ ] Cramping
  - [ ] Difficult to Pinpoint
  - [ ] Dull
  - [ ] Easy to Pinpoint
  - [ ] Exhausting
  - [ ] Heavy
  - [ ] Sharp
  - [ ] Shooting
  - [ ] Splitting
  - [ ] Stabbing
  - [ ] Tender
  - [ ] Throbbing
  - [ ] Tiring
  - [ ] Other:

- **Pain Management:**
  - [ ] Medication
  - [ ] Rest
  - [ ] Activity
  - [ ] Heat Application
  - [ ] Cold Application
  - [ ] Massage
  - [ ] T.E.N.S.
  - [ ] Leg Drop or Elevation
  - [ ] Other:

- **Is Current Pain Management Adequate?**
  - [ ] Adequate
  - [ ] Inadequate

- **Patient’s Stated Goals for Pain Management:**

- **Modification to Pain Management:**

- **WOUND IMPACT ON ACTIVITIES OF DAILY LIVING**

- **Dressing/Bathing:**
  - [ ] Yes
  - [ ] No

- **Eating:**
  - [ ] Yes
  - [ ] No

- **Ambulating:**
  - [ ] Yes
  - [ ] No

- **Toileting:**
  - [ ] Yes
  - [ ] No

- **Hygiene:**
  - [ ] Yes
  - [ ] No

- **Ability to use phone:**
  - [ ] Yes
  - [ ] No

- **Showering:**
  - [ ] Yes
  - [ ] No

- **Shopping:**
  - [ ] Yes
  - [ ] No

- **Food Preparation:**
  - [ ] Yes
  - [ ] No

- **Housekeeping:**
  - [ ] Yes
  - [ ] No

- **Laundry:**
  - [ ] Yes
  - [ ] No

- **Handle medications:**
  - [ ] Yes
  - [ ] No

- **Handle money:**
  - [ ] Yes
  - [ ] No

#### EDUCATION ASSESSMENT

- **Patient Assessed** or **Caregiver Assessed - Name of Caregiver:**

- **Translator Needed?**
  - [ ] No
  - [ ] Yes

- **Hospital Employed Language Interpreter**
  - [ ] Yes
  - [ ] No

- **Trained Bi-Lingual Staff**
  - [ ] Yes
  - [ ] No

- **Cultural/Religious Beliefs that would impact wound care - e.g. use of blood, porcine (pig) or bovine (cow) based tissue products:**
  - [ ] No
  - [ ] Yes

- **Impaired Vision:**
  - [ ] No
  - [ ] Glasses
  - [ ] Contacts
  - [ ] Legally Blind

- **Impaired Hearing:**
  - [ ] No
  - [ ] Complete Loss
  - [ ] Hearing Aid

- **Decreased Hand Dexterity:**
  - [ ] No
  - [ ] Limitations:

- **Knowledge Level of Health Problem:**
  - [ ] High
  - [ ] Medium
  - [ ] Low

- **Comprehension Level (Ability to Understand Concepts):**
  - [ ] High
  - [ ] Medium
  - [ ] Low

- **Ability to understand written instructions:**
  - [ ] High
  - [ ] Medium
  - [ ] Low

- **Ability to understand verbal instructions:**
  - [ ] High
  - [ ] Medium
  - [ ] Low

- **SELF HEALTH MANAGEMENT ASSESSMENT**

- **Willingness to engage in self-management activities:**
  - [ ] High
  - [ ] Medium
  - [ ] Low

- **Readiness to engage in self-management activities:**
  - [ ] High
  - [ ] Medium
  - [ ] Low

- **Anxiety Level:**
  - [ ] Calm
  - [ ] Anxious

- **Cooperation:**
  - [ ] Cooperative
  - [ ] Uncooperative

- **Perception:**
  - [ ] Coherent
  - [ ] Confuse

- **Interest in Health Problem:**
  - [ ] Asked Questions
  - [ ] Uninterested

- **Education Importance:**
  - [ ] Acknowledges Need
  - [ ] Denies Need

- **Other:**
  - [ ] Does Patient smoke tobacco or other substances?
    - [ ] Yes
    - [ ] No

- **Is Patient diabetic?**
  - [ ] Yes
  - [ ] No

#### NURSE’S NOTES