Texas Department
of Human Services

Form **3050**
July 1996

HEALTH ASSESSMENT/INDIVIDUAL SERVICE PLAN

SECTION I–IDENTIFICATION AND BACKGROUND INFORMATION

1. Client Name–Last		First	M.I.	2. Current Date of Admission
3. Client No.	4. Date of Birth (month/day/year)	5. Sex ☐ Male ☐ Female	6. Lives Alone ☐ Yes ☐ No	7. Reason for Assessment ☐ Initial ☐ Transfer ☐ Ongoing

SECTION II–HEALTH ASSESSMENT (if completed by Licensed Nurse) / CLIENT SELF-REPORT (if completed by facility staff based on client input)

A. Disease Diagnosis/Health Problems: Check only those diseases present that have a relationship to current ADL status, cognitive status, behavior status, medical treatments, or risk of death. (Do not list inactive diagnoses.)

1. Diseases (check all that apply)

☐ Allergies
☐ Alzheimer's Disease
☐ Anemia
☐ Aphasia
☐ Arteriosclerotic Heart Disease (ASHD)
☐ Arthritis
☐ Asthma
☐ Cancer-Type: ______
☐ Cardiac Dysrhythmia
☐ Cataracts
☐ Cerebral Palsy
☐ Cerebrovascular Accident (stroke)
☐ Congestive Heart Failure
☐ Dementia Other Than Alzheimer's
☐ Diabetes Mellitus
☐ Emphysema, COPD
☐ Glaucoma
☐ HIV Infection
☐ Hypotension
☐ Hypertension
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Parkinson's Disease
☐ Peripheral Vascular Disease
☐ Pneumonia
☐ Renal Disease (end stage)
☐ Seizure Disorder
Type: ______
Frequency: ______
☐ Tuberculosis
☐ Urinary Tract Infection (recurrent)

2. Other Current Diagnoses

______

3. Problems/Conditions and Signs/Symptoms (Check all problems that are present or that client has experienced in the last seven days.)

☐ Chest Pain
☐ Constipation
☐ Cough
☐ Diarrhea
☐ Dizziness, Vertigo
☐ Fecal Impaction
☐ Fever
☐ Generalized Weakness
☐ Headache
☐ Joint Pain
☐ Malnourished
☐ Obese
☐ Pain–Complains or shows evidence of pain daily or almost daily.
☐ Shortness of Breath
☐ Syncope (fainting)
☐ Tremors
☐ Upset Stomach/ Indigestion
☐ Vomiting
☐ Wheezing
☐ Other (specify): ______ ______

4. Edema (check all that apply)

☐ None ☐ Generalized ☐ Localized (not pitting) ☐ Pitting ☐ Other (specify):

B. Functional/Physical Status

COMMUNICATION/HEARING PATTERNS

1. Hearing (with hearing aid, if used)
☐ Hears Adequately-Normal Talk, TV, Phone ☐ Minimal Difficulty When Not in Quiet Setting ☐ Hears in Special Situation Only-Must Adjust Tonal Qual./Speak Distinctly ☐ Highly Impaired/ No Useful Hearing

2. Communication Devices/Techniques (check all that apply)
☐ Hearing Aid, Present and Used ☐ Hearing Aid, Present but not Used ☐ Other Receptive Communication Technique Used (e.g., lip read) ☐ Other

3. Making Self Understood
☐ Understood ☐ Usually Understood-Difficulty Finding Words/Finishing Thoughts ☐ Sometimes Understood-Ability is Limited to Making Concrete Requests ☐ Rarely/Never Understood

4. Ability to Understand Others
☐ Understands ☐ Usually Understands-May Miss Some Part of Intent or Message ☐ Sometimes Understands-Responds Adequately to Simple, Direct Communication ☐ Rarely/Never Understands

VISION PATTERNS

Vision (check all that apply)
☐ Adequate-Sees Fine Detail Including Newsprint ☐ Impaired-Sees Large Print but Not Regular Print (newsprint) ☐ Highly Impaired-Limited Vision; Not Able to See Newspaper Headlines (appears to follow objects with eyes)
☐ Severely Impaired-No Vision or Appears to See Only Light, Color, or Shapes ☐ Uses Glasses ☐ Uses Contacts ☐ Uses Magnifying Glass

PROBLEM BEHAVIOR

Problem Behavior (check all that apply)
☐ NONE ☐ Wandering (moves with no rational purpose) ☐ Verbally Abusive (others are threatened, screamed at, cursed) ☐ Failure to Eat or Take Medications
☐ Motor Agitation (pacing, handwringing, picking) ☐ Physically Abusive (others are hit, shoved, scratched) ☐ Socially Inappropriate or Disruptive Behavior (disruptive sounds, screams, self-abusive acts, sexual behavior or disrobing in public, throws food)

CONTINENCE

1. Bowel Continence–Control of bowel movement, with appliance or bowel continence programs, if employed
☐ Continent ☐ Occasionally Incontinent ☐ Incontinent

2. Bladder Continence–Control of urination (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if used.
☐ Continent ☐ Occasionally Incontinent ☐ Incontinent

SKIN CONDITION

1. Stasis Ulcer (open lesion caused by poor circulation to lower extremities)
☐ Yes ☐ No **If "Yes," describe:**

2. Pressure Ulcers (Record the number of sites for presence of each stage of pressure ulcers. If none are present at a stage, enter "0.")
☐ NONE

	No. Sites	Location
Stage 1: A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.		
Stage 2: A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.		
Stage 3: A full thickness of skin lost, exposing subcutaneous tissues–presents deep crater with/without undermining adjacent tissue.		
Stage 4: A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone.		

3. Other Skin Problems or Lesions Present (check all that apply)
☐ NONE ☐ Skin Desensitized to Pain, Pressure, Discomfort ☐ Abrasions, Bruises ☐ Surgical Wounds ☐ Cuts (other than surgery)
☐ Open Lesions Other than Stasis/Pressure Ulcers, or Cuts ☐ Dry, Fragile Skin ☐ Psoriasis ☐ Rashes

ORAL/DENTAL STATUS

Oral Problems
☐ NONE ☐ Chewing Problem ☐ Swallowing Problem ☐ Mouth Pain ☐ Broken, Loose, or Carious Teeth
☐ Debris (soft, easily movable substances) Present in Mouth ☐ Some or All Natural Teeth Lost–Does Not Have or Does Not Use Dentures (or partial plates) ☐ Inflamed Gums (gingiva), Swollen or Bleeding Gums, Oral Abscesses, Ulcers, or Rashes

BODY CONTROL PROBLEMS

(check all that apply)
☐ NONE ☐ Balance–Part or Total Loss of Ability to Balance While Standing (prone to falling) ☐ Hemiplegia or Hemiparesis ☐ Hand–Lack of Dexterity (e.g., problem using eating utensils or adjusting hearing aid)
☐ Arm–Part or Total Loss of Voluntary Movement ☐ Leg–Part or Total Loss of Voluntary Movement ☐ Leg–Unsteady Gait ☐ Trunk–Part or Total Loss of Ability to Position, Balance, or Turn Body ☐ Amputation

Contractures
☐ NONE ☐ Face or Neck ☐ Shoulder or Elbow ☐ Hand or Wrist ☐ Hip or Knee ☐ Foot or Ankle ☐ Other

VITAL SIGNS/HEIGHT/WEIGHT

BP	Pulse	Respiration	Temp. (optional)	Height	Weight

SECTION III–PLAN OF CARE

A. Personal Care Assistance Required at Facility

1. TRANSFER–How client moves between surfaces–To and from: bed, chair, wheelchair, standing position (exclude to and from bath and toilet)
☐ No Setup or Physical Help Required ☐ Setup Help Only ☐ One-Person Physical Assistance ☐ Two-Person Physical Assistance

2. LOCOMOTION–How client moves between locations
☐ No Setup or Physical Help Required ☐ Setup Help Only ☐ One-Person Physical Assistance ☐ Two-Person Physical Assistance

Mobility Appliances/Devices used at Facility (check all that apply)
☐ NONE ☐ Cane, Walker, Crutch ☐ Brace or Prosthesis ☐ Wheelchair–Wheels Self ☐ Wheelchair–Other Person Wheels
☐ Lifted Manually ☐ Lifted Mechanically ☐ Transfer Aid (e.g., slide board)

3. EATING–How client eats and drinks
☐ No Setup or Physical Help Required ☐ Setup Help Only ☐ One-Person Physical Assistance ☐ Two-Person Physical Assistance

Nutrition Approaches at Facility
☐ Parenteral/IV Fluid ☐ Feeding Tube ☐ Mechanically Altered Diet ☐ Syringe (oral feeding) ☐ Therapeutic Diet ☐ Dietary Supplement Between Meals
☐ Plate Guard, Stabilized Built-Up Utensil, etc. ☐ Other (specify):

4. TOILET USE–How client uses the toilet room, transfers on and off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes
☐ No Setup or Physical Help Required ☐ Setup Help Only ☐ One-Person Physical Assistance ☐ Two-Person Physical Assistance

Appliances and Programs (check all that apply)
☐ Any Scheduled Toileting Plan ☐ External (condom) Catheter ☐ Indwelling Catheter ☐ Intermittent Catheter ☐ Pads, Briefs ☐ Enemas, Irrigation ☐ Ostomy

5. MEDICATIONS (RN must complete for CBA/DAHS)
☐ No Medication ☐ **Self-Medications:** ☐ Independent ☐ Assist/Supervise/Remind ☐ Administration of Medications (nursing task)

6. PERSONAL HYGIENE–How client maintains personal hygiene, including hair care, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum.

☐ No Setup or Physical Help Required ☐ Setup Help Only ☐ One-Person Physical Assistance ☐ Two-Person Physical Assistance

☐ Daily Cleaning of Teeth or Dentures or Daily Mouth Care at Facility

7. TYPE OF BATH (check all that apply)

☐ Client does not bathe at Facility ☐ Client Bathes PRN at Facility ☐ Tub or Whirlpool Bath ☐ Shower ☐ Bed Bath ☐ Bath Lift ☐ Sponge Bath

BATHING–Assistance Provided

☐ Independent–No Help Provided ☐ Supervision–Oversight Help Only ☐ Physical Help Limited to Transfer Only ☐ Physical Help in Part of Bathing Activity ☐ Total Dependence

B. Special Treatments, Procedures, Training at Facility (FOR DAHS ONLY)

1. Special Care–Check treatments client currently receives or will receive at facility.

☐ Dressing Changes ☐ Monitoring Vital Signs ☐ Respiratory Care (Nebulizer, IPPB) ☐ Weight Monitoring

☐ Oxygen Therapy ☐ Diabetic Tests (urine, blood) ☐ Catheter Care ☐ Other (Specify): ____________

☐ Intake/Output ☐ Syringe or Tube Feeding ☐ Fluid Intake Monitoring

2. Active Skin Care Program at Facility (check all that apply)

☐ Turning or Repositioning Program ☐ Pressure Relieving Device (i.e. egg crate pads) ☐ Pressure Ulcer Care ☐ Surgical Wound Care ☐ Special Nutrition or Hydration Program

☐ Special Topical Applications of Lotion, Ointment, Medications ☐ Ostomy Care (e.g. trach) (routine and stable) ☐ Other (specify):

3. Foot Care Program at Facility (check all that apply)

☐ Foot Soaks ☐ Preventive or Protective Foot Care (e.g., special shoes, inserts, pads, toe separators, nail/callus trimming, etc.

☐ Dressing With and Without Topical Medications, Etc. ☐ Scheduled Monitoring of Condition of Feet ☐ Other (specify):

4. Rehabilitation/Restorative Care (check all that client receives at facility)

☐ **Range of Motion-Passive**–Specify Joint(s): ____________ ☐ **Range of Motion-Active**–Specify Joint(s): ____________

☐ Splint or Brace Assistance ☐ Reality Orientation ☐ Reminiscence Therapy/Remotivation

Training & Skill Practice In:

☐ Walking or Mobility ☐ Dressing or Grooming ☐ Eating or Swallowing ☐ Amputation Care ☐ Transfer ☐ Communication ☐ Other

5. Health Teaching to be Provided at Facility (check all that apply)

☐ Special Diet Requirements ☐ Symptoms to Report to Physician/Nurse ☐ Skin Care

☐ Medication Effects ☐ Diabetic Foot Care ☐ Other: ____________

☐ Methods to minimize or prevent health problems (e.g., use of adaptive equipment, adequate nutrition/hydration, proper positioning, use of elastic stockings, etc.) ____________

SECTION IV–THERAPIES

Check therapies client CURRENTLY receives from ANY source.

☐ Speech–Language Pathology, Audiology Services ☐ Psychological Therapy (licensed prof.)

☐ Occupational Therapy ☐ Respiratory Therapy ☐ Radiation

☐ Physical Therapy ☐ Chemotherapy ☐ Dialysis ☐ Other (Specify):

SECTION V–PARTICIPATION IN ASSESSMENT

Client	Family	Significant Other
☐ Yes ☐ No	☐ Yes ☐ No ☐ No Family	☐ Yes ☐ No ☐ None

Signature–Client or Responsible Person	Date
X	

Comments: ____________

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I certify that to the best of my knowledge, the information contained in this form is true and correct.

Date Assessment Completed (m/d/y)	Telephone No.

____
Signature–Person Completing Form
(Include RN or LVN credential as appropriate.)