Non-Medical Home Care Assessment Form

This Non-Medical Home Care Assessment Form provides a structured way to assess client needs, ensuring personalized care in their own homes. The form allows for detailed information about daily living needs, mobility, and personal preferences to guide caregivers in providing care that is tailored to the client's well-being.

Patient information	
Name: Zoe Sanders	
Date of birth: August 12, 1946	**Gender:** Female
Address: 123 Maple Street, Springfield, IL 62704	
Phone number: (217) 555-1234	**Email address:** zoe.sanders@email.com
Emergency contact: Sarah Sanders - (217) 555-5678	
Relationship: Daughter	
Caregiver information	
Assigned caregiver: Emily Smith	
Care agency (if applicable): ComfortCare Home Services	
Caregiver phone: (217) 555-7890	
Assessment date	
Date of assessment: October 10, 2024	
Assessor's name: John Doe	**Designation:** Home Care Nurse

I. Client's health and daily living needs

Medical history (if relevant for care context)	
Does the client have any chronic conditions? ◉ Yes ○ No	**If yes, list the conditions:** Hypertension Type 2 Diabetes Arthritis
Mobility	
Does the client have any mobility issues? ◉ Yes ○ No	**Requires assistance with:** ☑ Walking ☑ Climbing stairs ☑ Transfers (e.g., bed to chair)
Mobility devices used: Walker and stairlift	

Personal care needs

Bathing:

- ( ) Independent
- (•) Requires assistance

Dressing:

- ( ) Independent
- (•) Requires assistance

Grooming:

- (•) Independent
- ( ) Requires assistance

Toileting:

- (•) Independent
- ( ) Requires assistance

Nutrition and meals

Meal preparation:

- ( ) Independent
- (•) Requires assistance

Special diet requirements:

Low sodium diet (due to hypertension)
Diabetic-friendly meals

Requires assistance with eating?

- ( ) Yes
- (•) No

Household chores

Light housekeeping needed:

- (•) Yes
- ( ) No

Assistance with laundry?

- (•) Yes
- ( ) No

Home environment safety concerns:

Rugs present a tripping hazard
Requires additional handrails in the bathroom

Medication management

Is the client able to manage their own medications?

- ( ) Yes
- (•) No

Medication management assistance needed?

- (•) Yes
- ( ) No

Medication reminders required?

- (•) Yes
- ( ) No

II. Social and emotional needs

Companionship and mental health	
Does the client require social interaction or companionship? (●) Yes ( ) No	**Emotional support needs:** Regular social interaction to prevent loneliness
Mental health concerns (e.g., anxiety, depression):	
Mild anxiety due to limited mobility	
Family support	
Does the client have family members actively involved in their care? (●) Yes ( ) No	**Primary family caregivers:** Sarah Sanders

III. Daily schedule

Typical daily routine	
Wake-up time: 7:30 AM	**Bedtime:** 9:30 PM
Meal times:	**Errands needed:**
8:00 AM (breakfast), 12:30 PM (lunch), 6:30 PM (dinner)	Weekly grocery shopping; Monthly doctor visits
Assistance needed: (●) Yes ( ) No	

IV. Care plan and goals

Care goals
What are the main goals for the client's non-medical home care?
Enhance mobility through regular assisted walking Promote independence in personal care tasks Prevent social isolation through regular companionship

Strategies for achieving goals	
Discussed with client and/or family: (●) Yes ( ) No	**Key strategies (e.g., enhancing mobility, promoting independence, emotional support):** Daily assisted walks with the caregiver Encouraging self-care where possible, with support when needed Regular family visits and caregiver companionship
Respite care needs	
Is respite care required for the family caregivers? (●) Yes ( ) No	**Schedule for respite care (if applicable):** One weekend per month

V. Emergency protocols

Emergency contacts and information	
Emergency protocols in place: (●) Yes ( ) No	**List of emergency contacts and numbers:**
Does the client have a reasonable-cost emergency response system in place (e.g., alert device)? ( ) Yes ( ) No	
Health emergency plan	
What to do in case of a medical emergency (e.g., call 911, notify family):	
Call 911 immediately, then notify Sarah Sanders at (217) 555-5678	

Notes/additional information

Client requires a daily blood sugar check
Increased anxiety noted during evenings; recommend relaxation techniques before bed

Client/family sign-off

I agree with the care plan and assessment outlined above:

	October 10, 2024
Client signature	**Date**

	October 10, 2024
Family member signature (if applicable)	**Date**

Caregiver/assessor sign-off

I have completed the assessment and reviewed it with the client and family:

	October 10, 2024
Assessor signature	**Date**