## INITIAL ASSESSMENT FORM

**Use as paper template during assessments for scribbling notes, but ultimately enter the data into replica template on PMS patient file electronically.**

<table>
<thead>
<tr>
<th>Staff/students undertaking the assessment today:</th>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>More boxes open as needed</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Client/whānau and others present:</th>
<th>Name</th>
<th>Relationship to client/whānau</th>
</tr>
</thead>
<tbody>
<tr>
<td>More boxes open as needed</td>
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</table>

### Hui/Consult process
- Mihimihi
- Whakawhanaungatanga
- Kaupapa
- Poroporoaki

### SUBJECTIVE ASSESSMENT

#### Quick check for orientation
Ask client/whānau ‘what is today’s date’: …… / …… / ……
- ☐ Correct
- ☐ Incorrect

Notes: ………………………………………………………………………………………………………………………………………………………………………

#### Do you have any problems with understanding or remembering instructions given to you?:
- ☐ Yes
- ☐ No

Notes: ………………………………………………………………………………………………………………………………………………………………………

#### Do you wear glasses?:
- ☐ Yes
- ☐ No

Date of last eye exam: …… / …… / …… (single date field ok)
- ☐ Don’t know

#### Do you wear hearing aids?:
- ☐ Yes
- ☐ No

Date of last hearing exam: …… / …… / …… (single date field ok)
- ☐ Don’t know

#### Cultural factors/beliefs
In your culture are there some health practices that are important to you?
- ☐ Yes
- ☐ No

Notes: ………………………………………………………………………………………………………………………………………………………………………

Is faith or spirituality important to you?
- ☐ Yes
- ☐ No

Notes: ………………………………………………………………………………………………………………………………………………………………………

Are you part of any religious or spiritual community or congregation?
- ☐ Yes
- ☐ No

Notes: ………………………………………………………………………………………………………………………………………………………………………

#### Current diagnosis
- ☐ Asthma
- ☐ COPD
- ☐ Type 2 Diabetes
- ☐ Falls
- ☐ Cancer rehab
- ☐ Other
Other (specify): …………………………………………………………………………………………………………………………………………………

Date diagnosed: ……/……/…… Date of last medical annual review: ……/……/…… □ Don’t know (single date fields ok)

Current concerns: …………………………………………………………………………………………………………………………………………………

Client/whānau goals/expectations from Te Kotahi Oranga visit (formulate into three reasonable goals to achieve):

1. ……………………………………………………………………………………………………………………………………………………………
2. ……………………………………………………………………………………………………………………………………………………………
3. ……………………………………………………………………………………………………………………………………………………………

More lines as needed

Medical history

Do you have any other medical conditions?: □ Yes □ No

Notes:
……………………………………………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………………………………………………………

Do you have any known allergies (including drug allergy, food allergy or intolerances?)?: □ Yes □ No

Notes:
……………………………………………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………………………………………………………

Have you experienced any significant surgical, trauma, hospitalisation in your past?: □ Yes □ No

Tell me about this: …………………………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………………………………………………………

Family/whānau history

Does anyone in your immediate whānau have any significant medical problems, such as:

□ Asthma □ Heart problems □ Cancer □ Diabetes □ Mental Illness □ Other

Notes:
……………………………………………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………………………………………………………

Medications

Name and strength of medication | Dose and frequency
More boxes open as needed | More boxes open as needed

Medication adherence

Who administers the dose each day?: □ Self □ Partner/Carer

Notes:
……………………………………………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………………………………………………………

Who organises repeat prescriptions and collects your medications from the pharmacy? □ Self □ Partner/Carer

Notes:
……………………………………………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………………………………………………………

Say: Remembering to take medicine at the right times can be really hard, and many people miss a dose here and there. How do you get on with your medicine? Do you miss any doses?

Are there any missed doses per week?: □ Yes □ No

If yes, how many: □ 1-2 □ 3-4 □ 5-6 □ 7+
**Medication technique:**  
- [ ] Discussed and demonstrated  
- [ ] Discussed only

**Notes:**

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### Social History

### Occupation

Are you:

- [ ] Retired  
  Previous occupation: ..............................................................
- [ ] Employed (specify hours/type):

### Home and support

Do you:

- [ ] Live alone
- [ ] Have help at home (specify)
- [ ] Other (e.g. retirement home, assisted living)

**Notes:**

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Would you describe your house as:

- [ ] Warm, dry and well-insulated
- [ ] Cold, damp and uninsulated

**Notes:**

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Is your home:

- [ ] Single level  
  - [ ] Two-story

Do you have:

- [ ] Stairs in the house  
- [ ] Stairs outside house (e.g. for access)
- [ ] Pet(s) in the house (specify): ............................................

Do you have any handrails in your house?  
- [ ] Yes  
- [ ] No

**Other access/falls risk issues to note:** ..............................................

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### Feeling safe at home:

Have you ever felt unsafe at home?  
- [ ] Yes  
- [ ] No

**Notes:**

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Do you ever feel that you have no choice or control in family decision-making?  
- [ ] Yes  
- [ ] No

**Notes:**

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Do you ever feel humiliated or demoralised by your partner/husband/wife?  
- [ ] Yes  
- [ ] No

**Notes:**

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During altercations, have you ever felt fearful?  
- [ ] Yes  
- [ ] No
**Support network (any family nearby, neighbours, support groups):**
Tell me about your support network. Do you have family nearby? Neighbours you can rely on? Do you belong to any social/support groups?

**Social interests/hobbies**
Tell me about your social interest and hobbies, things you like to do:

**Nutrition**
Have you noticed any change in your weight in the last 3 months?: ☐ Yes ☐ No
Tell me about this: …………………………………………………………………………………………………………………………………………………

Do you have any problems with your teeth and gums that affects swallowing or eating?: ☐ Yes ☐ No

Last dental check up: ……/……/…… (single date field ok) ☐ Don’t know

**Who is the person who does the grocery shopping?:**
☐ Self ☐ Someone else

**Who is the person who prepares the meals?:**
☐ Self ☐ Eats mainly takeaways ☐ Someone else prepares meals

**What is a typical description of your (include type/quantity, e.g. white or brown bread and how many slices):**

Breakfast: …………………………………………………………………………………………………………………………………………………

Lunch: ………………………………………………………………………………………………………………………………………………………

Evening meals: …………………………………………………………………………………………………………………………………………

Snacks: …………………………………………………………………………………………………………………………………………………

Fluid intake:

Alcohol consumption: Do you consume more than 2 alcoholic drinks in a day/evening OR drink more than 5 days in a week? ☐ Yes ☐ No

Notes:

An answer of ‘Yes’ to any of these questions is an automatic referral to social worker

Notes: ……………………………………………………………………………………………………………………………………………………………………

Who is the person who prepares the meals?:

Who is the person who does the grocery shopping?:

Notes: ……………………………………………………………………………………………………………………………………………………………………

Notes: ……………………………………………………………………………………………………………………………………………………………………

Notes: ……………………………………………………………………………………………………………………………………………………………………

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Notes: ……………………………………………………………………………………………………………………………………………………………………

Notes: ……………………………………………………………………………………………………………………………………………………………………
Overall rating of meals based on description e.g.:
- Dinner: 'half plate' vegetables, ¼ plate protein, ¼ plate carbs
- Snacks: low sugar, low carbs, high grains, fruit and protein
- Lunch and breakfast: low sugar, low carbs, high protein, fruit and protein

Client/whānau perception of what they eat:
- Mostly healthy
- Needs improvement
- Unhealthy

Assessor perception of what client/whānau eats:
- Mostly healthy
- Needs improvement
- Unhealthy

Notes:

Exercise and activity

Are you able to walk for longer than 30 minutes in one session?:
- Yes
- No
- Don’t know

If not, what stops you?:
- Pain
- Shortness of breath
- Cramp
- Other:

How do you normally get to places (e.g. uses car with valid license, car, bus, etc)?:

How many times a week are you active (activities that increase working of breathing)?:
- 0
- 1-2
- 3-4
- 5+

How long are you active for per session?:
- Less than 30 mins
- 30-45 mins
- 1 hour or longer

Notes:

What kind of activity do you do?:
- Walking
- Jogging/Running
- Gym class
- Bike
- Swim
- Housework/outside tasks
- Other (Specify)

Sleep

How many hours sleep do you get a night?:
- Less than 4
- 4-6
- 7+

Do you experience any breathlessness at night?:
- Yes
- No

How many pillows do you use?:
- 1 or none
- 2-3
- More than 3

Has anyone ever told you, or have you experienced, episodes of stopping breathing in your sleep?:
- Yes
- No

Do you experience constant waking at night/insomnia?:
- Yes
- No

Notes/concerns:

Mobility

Do you have any problems with your mobility (getting around, out of a chair, on/off toilet etc)?:
- Yes
- No

Notes:

Do you use a mobility aid?:
- Yes
- No

- Walking stick
- Walking frame
- Scooter
- Other
### Pain
Do you experience any pain anywhere in your body?:  
- [ ] Yes  
- [ ] No

If yes - tell me about your pain (where, how bad, how long etc)

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### Smoking/vaping history
Does anybody in the home smoke or vape?:  
- [ ] Yes  
- [ ] No

Who smokes/vapes in the home?

*(If it is the client, ask ‘are you ok to tell me more about it?’ and fill in ‘currently smoking/vaping’ info)*

*(If client answers ‘no’ to previous question)*

Have you ever smoked/vaped?

- [ ] Never smoked/vaped  
- [ ] Ex-smoker  
- [ ] Smoke exposed/previously smoke exposed

Smoking history:

- [ ] Currently smoking

Amount/frequency/plans to quit:

Quitting advice  
- [ ] Accepted  
- [ ] Declined

Advice given:

- [ ] Currently vaping

Amount/frequency/plans to quit:

Quitting advice  
- [ ] Accepted  
- [ ] Declined

Advice given:

Do you use recreational drugs?:  
- [ ] Yes  
- [ ] No

Notes and history of use:

---

### Mental well-being
Would you say you are experiencing a high level of stress in your life right now?:  
- [ ] Yes  
- [ ] No

Please tell me more, if you would like to:

Do you ever have feelings of not coping or deep sadness?:  
- [ ] Yes  
- [ ] No

Please tell me more, if you would like to:

Have you ever experienced significant mood changes?:  
- [ ] Yes  
- [ ] No

Please tell me more, if you would like to:

---

### Financial
Because of limited income or financial difficulties, during the past month have you struggled to purchase:

- [ ] Food  
- [ ] Medical care  
- [ ] Medications or supplies  
- [ ] Transport

Please tell me more, if you would like to:
# Objective Assessment

**Blood Pressure**

<table>
<thead>
<tr>
<th>Sitting</th>
<th>5 min Lying Down</th>
<th>1 min Standing</th>
<th>3 min Standing</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>BP</td>
<td>BP</td>
<td>BP</td>
</tr>
<tr>
<td>PR</td>
<td>PR</td>
<td>PR</td>
<td>PR</td>
</tr>
<tr>
<td>SPO₂</td>
<td>SPO₂</td>
<td>SPO₂</td>
<td>SPO₂</td>
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</tbody>
</table>

Reduction in systolic BP of ≥ 20 mmHg or in diastolic BP of ≥ 10 mmHg within 3 mins of standing:  
☐ Yes  ☐ No

Light-headedness or dizziness on standing:  
☐ Yes  ☐ No

Notes:  
………………………………………………………………………………………………………………………………………………………………..

**Blood glucose**

HbA1c  
☐ Below 40  
☐ Between 40-50  
☐ Over 50

OR

Random Blood Glucose *(people with diabetes only): …… mmol/L*

Last ate:  
☐ < 1 hour  
☐ 2-4 hours  
☐ > 4 hours

Notes:  
…………………………………………………………………………………………………………………………………………………………

Have you experienced a hypoglycaemic incident within last 3 months *(people with diabetes only):  
☐ Yes  ☐ No  ☐ N/A

If yes, what happened to cause this?:  
…………………………………………………………………………………………………………………………………………………………

**Lipids**

<table>
<thead>
<tr>
<th>CHOL</th>
<th>TG</th>
<th>HDL</th>
<th>LDL</th>
<th>Non-HDL</th>
<th>CHOL/HDL</th>
</tr>
</thead>
<tbody>
<tr>
<td>…… mmol/L</td>
<td>…… mmol/L</td>
<td>…… mmol/L</td>
<td>…… mmol/L</td>
<td>…… mmol/L</td>
<td>……</td>
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</tbody>
</table>

**Cardiovascular Risk Assessment Score** *(https://cvrisk.mohio.co.nz/): …… % *(people with diabetes only):

**Measurements**

<table>
<thead>
<tr>
<th>Weight (kg):</th>
<th>Height (m):</th>
<th>BMI (kg/m²):</th>
<th>Waist (cm):</th>
</tr>
</thead>
<tbody>
<tr>
<td>……</td>
<td>……</td>
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<td>……</td>
</tr>
</tbody>
</table>

**Respiratory**

Respiratory rate: …… breaths/min

Any comments and observations about client/whānau breathing:

Do you experience any shortness of breath?:  
☐ Yes  ☐ No

If yes, mMRC Dyspnea Scale score:  
☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4

Tell me about this:  
…………………………………………………………………………………………………………………………………………………………

Do you experience any regular coughing?:  
☐ Yes  ☐ No

Tell me more about this (when, dry/wet, productive, any associated urinary incontinence):  
…………………………………………………………………………………………………………………………………………………………
### Asthma (people with asthma only)

#### Asthma Control Test Score: ([https://www.asthmacontroltest.com/](https://www.asthmacontroltest.com/))
- □ 20-25 well controlled
- □ 16-19 partly controlled
- □ 05-15 poorly controlled

#### How many times a week is the reliever medicine required? *(anything more than twice a week is a red flag)*
- □ <1
- □ 1-2
- □ 3-4
- □ 5+

#### Any need for oral steroids (e.g. prednisone) since last visit?:  
- □ Yes  
- □ No

#### Notes:

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### Do you have an up to date Action Plan in place? *(people with asthma and COPD only):*  
- □ Yes  
- □ No

---

### Cognitive screening

#### Mini-Ace Score:  
- □ Version A  
- □ Version B  
- □ Version C

| Attention: | 0-4 |  
| Memory: | 0-7 |  
| Fluency: | 0-7 |  
| Visospatial: | 0-5 |  
| Memory recall: | 0-7 |  

**Total** /30

#### Notes:

---

### Falls Risk - screening

#### Have you ever experienced a fall?:  
- □ Yes  
- □ No

#### What happened?:

#### Number of trips, slips, falls or near falls, in last year:  
- □ 0  
- □ 1  
- □ 2  
- □ 3  
- □ 4+

#### Notes:

---

#### Are you able to get out of a chair without using hands? *(observe):*  
- □ Yes  
- □ No

#### Do you limit or avoid activities because you are afraid of losing balance or falling?:  
- □ Yes  
- □ No

#### Do you feel unsteady when you are standing or walking?:  
- □ Yes  
- □ No

#### Do you ever experience dizziness e.g. with getting up, moving your head, turning, etc?:  
- □ Yes  
- □ No

#### Notes:

---

### Falls Risk Assessment

#### Timed up and go test ≥ 12 seconds:  
- □ Yes  
- □ No  

#### Time:

---
### 30-second Chair Stand Test:
- Number: [ ]
- Below average score: [ ] Yes [ ] No

### Four-stage Balance Test:
- Parallel stance time: [ ]
  - Less than 10 seconds?: [ ] Yes [ ] No
- Semi-tandem stance time: [ ]
  - Less than 10 seconds?: [ ] Yes [ ] No
- Tandem (heel-toe) stance time: [ ]
  - Less than 10 seconds?: [ ] Yes [ ] No
- One-legged stance time: [ ]
  - Less than 10 seconds?: [ ] Yes [ ] No

*Client/whānau aged 65 years or older who do not progress to the tandem (heel-toe) stance or cannot hold this stance for at least ten seconds are at increased risk of falling.*

Based on your findings, is this client/whānau a falls risk? [ ] Yes [ ] No

### Six Minute Walk Test distance:
- Distance: [ ]
  - Not tested in this assessment: [ ]

### Romberg Test:
- Positive: [ ]
  - Negative: [ ]
  - Not tested in this assessment: [ ]

### Foot assessment

#### Left foot sensation
- Touch Toe Test - sensation felt zones:
  - Red [ ]
  - Blue [ ]
  - Green [ ]
  - Orange [ ]
  - Purple [ ]
  - Yellow [ ]

- Pulses felt:
  - Dorsalis Pedis [ ]
  - Posterior Tibialis [ ]

- Observations:
  - Warm and well perfused [ ]
  - Cool and clammy [ ]
  - Corns or callus [ ]
  - Pathological nails [ ]
  - Ulceration/previous ulcer [ ]
  - Previous amputation [ ]
  - Areas of poor skin integrity [ ]
  - Presence of structural issues [ ]

- Comments:

#### Right foot sensation
- Touch Toe Test - sensation felt zones:
  - Red [ ]
  - Blue [ ]
  - Green [ ]
  - Orange [ ]
  - Purple [ ]
  - Yellow [ ]

- Pulses felt:
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  - Pathological nails [ ]
  - Ulceration/previous ulcer [ ]
  - Previous amputation [ ]
  - Areas of poor skin integrity [ ]
  - Presence of structural issues [ ]

- Comments:
### ANALYSIS (taking into consideration client/whānau goals/expectations at the beginning of assessment)

<table>
<thead>
<tr>
<th>Subjective findings of concern:</th>
<th>Suggested plan for these areas of concern:</th>
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<tbody>
<tr>
<td>More boxes open as needed</td>
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<table>
<thead>
<tr>
<th>Objective findings of concern:</th>
<th>Suggested plan for these areas of concern:</th>
</tr>
</thead>
<tbody>
<tr>
<td>More boxes open as needed</td>
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<thead>
<tr>
<th>Overall impression:</th>
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### PLAN

<table>
<thead>
<tr>
<th>Recommendation to IP team going forward:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Home visit recommended?</th>
<th>Yes</th>
<th>No</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Referrals required:</th>
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