Home Care Client Assessment Form

Non-medical home care. For planning care and support services only, not a medical or skilled nursing assessment. Built to be completed in one sitting during a first in-home visit, in about 45 minutes.

DATE OF ASSESSMENT _____ ASSESSOR NAME _____

01 Client demographics

Full name	Preferred name
Date of birth	Gender
Height	Weight
Primary language	Phone
Home address	

Lives with ☐ Alone ☐ Spouse/partner ☐ Adult child ☐ Other family ☐ Roommate ☐ Other: _____

02 Emergency contacts and responsible party

Emergency contact 1	Emergency contact 2	Responsible party
Name	Name	Name
Relationship	Relationship	Relationship
Phone	Phone	Phone
Address	Address	Email

Responsible party: the person who handles decisions or payment, if different from the client.

Has legal authority? ☐ Power of Attorney ☐ Healthcare proxy ☐ Guardian ☐ None ☐ Unsure

03 Medical background

For care planning only. Record what the client or family reports. Do not diagnose.

Conditions and diagnoses (as reported by client or family)

CONDITION / DIAGNOSIS	SINCE (YEAR, IF KNOWN)	NOTES

Prognosis or expected changes (in the family's words, if shared)

Allergies (food, medication, environmental)

ALLERGY	REACTION

☐ No known allergies

Current medications (copy exactly from labels or med list)

MEDICATION	DOSAGE	SCHEDULE (TIMES OF DAY)	TAKEN INDEPENDENTLY?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Who currently manages medications? _____

04 Functional limitations

AREA	STATUS	NOTES
Ambulation (walking, mobility)	☐ No limitation ☐ Uses aid ☐ Limited ☐ Unable	
Vision	☐ No limitation ☐ Wears glasses ☐ Limited ☐ Legally blind	
Hearing	☐ No limitation ☐ Uses hearing aid ☐ Limited ☐ Deaf	
Cognition (memory, orientation)	☐ No limitation ☐ Mild concerns ☐ Moderate ☐ Significant	

Mobility aids in use: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Rollator ☐ None ☐ Other: _____

05 Activities of daily living (ADLs)

Rate each based on what you observe and what the client tells you.

ACTIVITY	INDEPENDENT	REQUIRES ASSISTANCE	DEPENDENT	NOTES
Ambulation and transfer	☐	☐	☐	
Bathing	☐	☐	☐	
Dressing and grooming	☐	☐	☐	
Toileting	☐	☐	☐	
Eating	☐	☐	☐	

06 Instrumental activities of daily living (IADLs)

ACTIVITY	INDEPENDENT	REQUIRES ASSISTANCE	DEPENDENT	NOTES
Medication management	☐	☐	☐	
Preparing meals	☐	☐	☐	
Housework	☐	☐	☐	
Laundry	☐	☐	☐	
Shopping	☐	☐	☐	
Transportation	☐	☐	☐	
Pet care	☐	☐	☐	

07 Home safety observations

Walk through the home. Look at the bathroom, the stairs, and the path the client takes most often.

ITEM	OBSERVATION
Stairs (inside or entry)	☐ None ☐ Present, has railing ☐ Present, no railing Notes: _____
Bathroom hazards	☐ Grab bars present ☐ No grab bars ☐ Slippery floor ☐ Raised toilet seat ☐ Shower chair Notes: _____
Lighting	☐ Adequate ☐ Poor in some areas Notes: _____
Clutter or trip hazards	☐ None ☐ Some ☐ Significant Notes: _____
Equipment in use	☐ Hospital bed ☐ Lift ☐ Oxygen ☐ Commode ☐ None ☐ Other: _____
Smoke and CO detectors	☐ Present ☐ Not seen ☐ Unsure
Falls in the last 12 months	☐ None ☐ 1 ☐ 2 to 3 ☐ 4 or more Details: _____
Other safety notes	

08 Caregiver match preferences

Mark whether each preference is Required or Preferred.

PREFERENCE	DETAIL	REQUIRED	PREFERRED
Caregiver gender	☐ Female ☐ Male ☐ No preference	☐	☐
Smoking	☐ Non-smoker only	☐	☐
Comfortable with pets	☐ Yes Pet type: _____	☐	☐
Language spoken	_____	☐	☐
Dementia experience		☐	☐
Other preferences			

09 Care goals

In the client's or family's own words. Write what they say.

10 Proposed schedule

Days of the week	☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun
Start time	
End time	
Hours per visit	
Total hours per week	
Preferred start date	
Notes on timing or flexibility	

11 Signatures

Keep the signed original in the client file and give the family a copy.

ROLE	SIGNATURE	PRINTED NAME	DATE
Assessor			
Client or responsible party			