Nursing Assessment

Demographics

Date: 05/12/2015 **Admit Date:** **Time Begun:** 12:40pm **Time Ended:**

Presenting Problem:

Client Name: John Doe **Patient ID#:** 1

Address: ,

Telephone (Home): **Cell:**

Date of Birth: **Age:** **Sex:**

Email:

Social Security #:

Vital Signs

Temperature: **Pulse:** **Respirations:** **Blood Pressure:**

Height (ft): **Height (in):** **Weight** 125 **BMI:**

Waist (in):

If BAC positive repeat 1 hour and PRN until decreasing

BAC/ Breathalyzer:

Time **BAC**

Time **BAC**

Time **BAC**

UDS Results

Pupil Size: ☐ **Equal** ☐ **Pinpoint** ☐ **Reactive** ☐ **Dilated** ☐ **Other**

Substance Abuse History

Substance	Current Usage Past 30 Days	If yes, pattern of use last 30 days (include amount and frequency)	Age of 1st Use	Age this became a problem?	Pattern of use for at least last 6 months (include amount and frequency)	Primary Route:(Oral, IV, etc.)	Date, Time, and amount of last use
Alcohol	○ No ◉ Yes						
Amphetamines	○ No ○ Yes						
Barbiturates	○ No ○ Yes						
Benzodiazepines	○ No ○ Yes						
Xanax	○ No ○ Yes						
Valium	○ No ○ Yes						
Klonopin	○ No ○ Yes						
Cocaine	○ No ○ Yes						
Hallucinogens	○ No ○ Yes						
Inhalants	○ No ○ Yes						
Marijuana	○ No ○ Yes						
Methamphetamine	○ No ○ Yes						
Opioids	○ No ○ Yes						
Hydrocodone	○ No ○ Yes						
Oxycodone	○ No ○ Yes						
Morphine	○ No ○ Yes						
Methadone	○ No ○ Yes						
Heroin	○ No ○ Yes						
Oxycontin	○ No ○ Yes						
Other opioid	○ No ○ Yes						
Bath Salts	○ No ○ Yes						

Allergy Information

Type	Allergy	Reaction
Medication Allergy		
Food Allergy		
Environmental Allergy		

Mobility

Do you use any assistive devices (i.e.: wheelchair, walking devices, etc.) ○ No ◉ Yes

☐ **Any other equipment or special needs required to complete ADL's?**

Withdrawal Screening

Withdrawal Symptoms evident on admission:

Nausea:	☐ Current	☐ Past	**Headaches:**	☐ Current	☐ Past
Vomiting:	☐ Current	☐ Past	**Bowel Problems:**	☐ Current	☐ Past
Elevated Pulse:	☐ Current	☐ Past	**Elimination**	☐ Current	☐ Past
Elevated temperature:	☐ Current	☐ Past	**Anxiety:**	☐ Current	☐ Past
Abdominal cramping:	☐ Current	☐ Past	**Piloerection:**	☐ Current	☐ Past
Appetite disturbance:	☐ Current	☐ Past	**Lacrimation:**	☐ Current	☐ Past
Hot/cold flashes:	☐ Current	☐ Past	**Anorexia:**	☐ Current	☐ Past
Angry outbursts:	☐ Current	☐ Past	**Arthralgias:**	☐ Current	☐ Past
Restlessness:	☐ Current	☐ Past	**Myalgias:**	☐ Current	☐ Past
Rhinorrhea:	☐ Current	☐ Past	**Sweats:**	☐ Current	☐ Past
Craving:	☐ Current	☐ Past	**Tremors:**	☐ Current	☐ Past
Insomnia:	☐ Current	☐ Past	**Chills:**	☐ Current	☐ Past
Hallucinations:	☐ Current	☐ Past	**Mydriasis:**	☐ Current	☐ Past
Delusions:	☐ Current	☐ Past	**Depression:**	☐ Current	☐ Past
Paranoia:	☐ Current				

☐ **Past**

Number of times

Delirium Tremens ○ No ◉ Yes **Last Experienced:**

Describe:

Number of times

Seizures ○ No ◉ Yes **Last Experienced:**

Describe:

Other Withdrawal Screening

Other ○ No ◉ Yes **Last Experienced:**

Describe:

History of Blackouts? ○ No ◉ Yes ☐ **Recent** ☐ **Past**

If Yes, pattern:

Describe:

Have you ever been hospitalized due to your alcohol/drug use? ○ No ◉ Yes

If Yes, when and why?

Have you been hospitalized in the past 30 days? ○ No ◉ Yes

If Yes, describe:

Have you been seen in the ER in the last 30 days? ○ No ◉ Yes

If Yes, describe:

Have you had an injury in the last 30 days? ○ No ◉ Yes

If Yes, describe:

Have you ever engaged in IV drug use? ○ No ◉ Yes

Have you ever shared needles? ○ No ◉ Yes

Have you engaged in sexual activity with anyone whose health status is unknown to you? ○ No ◉ Yes

Have you engaged in sexual activity with partners who were diagnosed with any of the following?

☐ **HIV** ☐ **AIDS** ☐ **Hepatitis** ☐ **Gonorrhea** ☐ **Chlamydia** ☐ **Syphilis**

Chemical Dependence Treatment History

Have you ever been treated for a substance abuse issue? ○ No ◉ Yes

If Yes, list treatment

	Dates of Treatment	Level of Care	Length of Stay	Length of Sobriety	Outcome: If relapsed, why?

Key:

Level 1: OUTPATIENT SERVICES (including traditional outpatient treatment or ambulatory detox without extended on-site monitoring.)

Level 2: INTENSIVE OUTPATIENT / PARTIAL HOSPITALIZATION SERVICES (including ambulatory detox with extensive on-site monitoring)

Level 3: RESIDENTIAL / INPATIENT SERVICES

Level 4: MEDICALLY MANAGED INTENSIVE INPATIENT SERVICES

Mental Health Treatment History

Have you ever been given a psychiatric diagnosis? ○ No ◉ Yes

If Yes, diagnosis:

Who made the diagnosis: **When?**

Have you received mental health services or are you currently receiving services? ○ No ◉ Yes

If Yes, list treatments

	Date of Treatment	Level of Care	Duration of Treatment	Diagnosis or Reason in Treatment

Other details:

Nutritional Assessment

Weight change during past 6 months: ○ Gained ○ Lost

Approximate # of lbs

Explain any fluctuations:

Was weight gain or weight loss related to drug use ○ No ◉ Yes

Was weight gain or weight loss related to MH symptoms ○ No ◉ Yes

Special diet: ○ No ◉ Yes

If Yes, type:

Assessment of nutritional habits:

Does patient understand the basics of a healthy diet? ○ No ◉ Yes

Does patient use food as a coping mechanism? ○ No ◉ Yes

If Yes, explain:

History of eating disorder: ○ No ◉ Yes

If Yes, type: ○ Anorexia ○ Bulimia ○ Bulimarexia

Received treatment: ○ No ◉ Yes

If Yes, when and where:

Level of physical activity:

Nutritional Screen for Dietitian:

Further assessment is needed in the following areas (check all that apply):

☐ **No Referral Needed**

☐ **Ileostomy**
☐ **Cirrhosis**
☐ **Idiosyncratic Diet (Pica, etc.)**
☐ **AIDS/HIV+**
☐ **Acute Pancreatitis**
☐ **Diabetes (new) w/o ADA diet order**
☐ **HTN w/o low sodium diet**
☐ **New Onset Diabetes**
☐ **Renal Disease w/o Diet**
☐ **Diagnosis of Malnutrition**
☐ **Low-fat Diet**
☐ **Anorexia/Bulimia/Bulimarexia**
☐ **Compulsive Overeating**
☐ **Obesity**

Date R.D. Consult sent:

Medical

Do you have current medical problems? ○ No ◉ Yes

If Yes, explain:

☐ **Client denies history of surgery or hospitalization**

Surgical and Hospitalization History:

Facility	City/State	Date(s) Treated	Length of Stay	Reason

Please list any pertinent medical history in the client's family:

Do you currently have a Primary Care Physician? ○ No ◉ Yes

If Yes, name:

Date of last Physical:

Reason for last visit:

Do you currently use non-medication treatment methods, such as acupuncture, chiropractic? ○ No ◉ Yes

If Yes, list treatment method and date of last visit

Medications

☐ **No medications on admission**

Herbal supplements, vitamin supplements, mineral supplements, and/or homeopathic remedies currently used:

Systems Review