

NEW ADMISSION QUESTIONNAIRE

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Admit date/from: \_\_\_\_\_ Room #: \_\_\_\_\_

Physician: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Lived Alone: \_\_\_\_\_ With whom: \_\_\_\_\_

Place of living prior to admit: \_\_\_\_\_

Any other nursing home/assisted living/rehab or home health: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Marital status: \_\_\_\_\_, if widowed how long? \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_ Read/writes: \_\_\_\_\_

Religion: \_\_\_\_\_ Member: \_\_\_\_\_ Votes: \_\_\_\_\_

Veteran/spouse of veteran: \_\_\_\_\_ Tobacco use: \_\_\_\_\_

Alcohol use: \_\_\_\_\_ Substance abuse: \_\_\_\_\_ Insomnia: \_\_\_\_\_

Hospital stays in last 90 days: \_\_\_\_\_

ER visits in last 90 days: \_\_\_\_\_

Cognitive status: Short term memory: \_\_\_\_\_ Long term memory: \_\_\_\_\_

Decisions: \_\_\_\_\_ Mood Behaviors: \_\_\_\_\_

Vision: \_\_\_\_\_ Glasses: \_\_\_\_\_ Cataracts/lens implant: \_\_\_\_\_

Speech: \_\_\_\_\_ Hearing: \_\_\_\_\_ Devices used: \_\_\_\_\_

B&B habits: \_\_\_\_\_ Catheter: \_\_\_\_\_

History of: constipation \_\_\_\_\_ diarrhea \_\_\_\_\_ nausea \_\_\_\_\_ vomiting \_\_\_\_\_

Routine use of: stool softeners \_\_\_\_\_ laxatives \_\_\_\_\_ enemas \_\_\_\_\_

Usual weight: \_\_\_\_\_ Recent loss/gain, if so due to \_\_\_\_\_

Food Allergies: \_\_\_\_\_

#### Particular food preferences

Likes: \_\_\_\_\_

Dislikes: \_\_\_\_\_

Snacks: \_\_\_\_\_

Dentures \_\_\_\_\_ edentulous \_\_\_\_\_ natural teeth \_\_\_\_\_

Oral status: \_\_\_\_\_ Chewing status: \_\_\_\_\_

Daily routine/interest in last year: \_\_\_\_\_

Ability to bathe, dress, and do own personal hygiene: \_\_\_\_\_alone \_\_\_\_\_assist

Locomotion/transfer ability prior to admit: \_\_\_\_\_

Need non skid rubber sole shoes: \_\_\_\_\_ Range of motion/contractures: \_\_\_\_\_

Falls in last 180 days: \_\_\_\_\_ Falls in last 30 days: \_\_\_\_\_

Reason: \_\_\_\_\_

Any injuries: \_\_\_\_\_

History of Diabetes: \_\_\_\_\_ Seizures: \_\_\_\_\_ Stroke: \_\_\_\_\_ Cardiac Problems: \_\_\_\_\_

Condition of skin: \_\_\_\_\_ Current history of skin Breakdown: \_\_\_\_\_

Able to turn and reposition in bed: yes \_\_\_\_\_ no \_\_\_\_\_ needs help \_\_\_\_\_

Usual bath time: \_\_\_\_\_ type: \_\_\_\_\_

Gets up early: \_\_\_\_\_ To bed early: \_\_\_\_\_ Naps: \_\_\_\_\_

Recent overall decline: \_\_\_\_\_ due to: \_\_\_\_\_

Long or short term stay: \_\_\_\_\_

Advance Directives: \_\_\_\_\_ Power of attorney: \_\_\_\_\_

Pneumonia vaccine: \_\_\_\_\_ Flu vaccine: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Information Obtained from: \_\_\_\_\_

Resident's attitude toward placement: \_\_\_\_\_

Number of children: \_\_\_\_\_ Number of children living: \_\_\_\_\_

Clubs/Organizations: \_\_\_\_\_

Activities they like: cards \_\_\_\_\_ games \_\_\_\_\_ music \_\_\_\_\_ T.V. \_\_\_\_\_

Movies \_\_\_\_\_ gardening/plants \_\_\_\_\_ Favorite color: \_\_\_\_\_

Hobbies \_\_\_\_\_

Do they have a pet: \_\_\_\_\_ Do they like pets: \_\_\_\_\_