UW Eldercare Initiative
Basic Older Adult Needs Assessment

Date: _____

Name: _____

Age: _____ Marital status:_____ Sex:_____

Current situation:

MEDICAL AND PSYCHOLOGICAL INFORMATION
Primary physician:

Diagnosis:*

Medicines:

Can self-manage medications?

Cognitive Impairment (Memory Loss):*

Reason for memory loss:

Personality:*

Personal strengths:

FUNCTIONAL LIMITATIONS: What can person do/not do?
Incontinence: Bladder Self-care?

Bowel Self-care?

Nighttime behavior:*
Gets up on own?

Needs commode by bed?

Needs help occasionally?

Needs assistance every night?

Mobility:*
Unassisted?

Cane or Walker?

Elbow assist?

Wheelchair (1 or 2 person assist)?

Tasks	no problem	mid-mod assist	max assist
Food shopping			
Meal prep			
Eating			
Dressing			
Bathing			
Hygiene			
Housekeeping			
Laundry			
Bill-paying			
Transportation			
Yard work			

Comments:

Lifestyle preferences:

Pets:

Likes to do during the day:

SIGNIFICANT OTHERS:*

Name	Relationship	Capacity to help	DPOA

FINANCIAL RESOURCES:*

Monthly income: Savings:

Long-term care insurance:

Own home? Value?

Possible degree of difficulty selling/renting home:

Encumbrances on assets:

Other problems or issues:

*** = Key factors in determining needs & costs & services available**