ALORA RETREAT

Client's Assessment

Client's Name:

Date of Birth: **Gender:**

Address:

PLEASE INDICATE in the column which describes the Client's needs in each area.

ACTIVITY	FULL ASSIST	PARTIAL ASSIST	PROMPT	NOT REQUIRED
1.0 Daily Living Activities				
Personal Hygiene				
Bathing / showering	○	○	○	○
Grooming	○	○	○	○
Personal hygiene (teeth cleaning, shaving)	○	○	○	○
Diabetic footcare	○	○	○	○
Continence				
Managing continence	○	○	○	○
Toileting	○	○	○	○
Continence aids	○	○	○	○
Eating				
Eating	○	○	○	○
Eating aids	○	○	○	○

Food Allergies:	
Food (like/dislike):	

Dressing				
Dressing	○	○	○	○
Undressing	○	○	○	○

ACTIVITY	YES	NO	COMMENTS
1.0 Daily Living Activities (cont.)			

Mobility

Ambulant	○	○	
Walking stick	○	○	
Walker	○	○	
Wheelchair	○	○	
Negotiating stairs	○	○	
Is there a risk of falls?	○	○	

Communication

Assistive Technology	○	○	

Dietary Requirement / Restrictions

Diabetic / Sugar Free	
Gluten Free	
Dairy Free	
Vegan	
Vegetarian	
Religious	

ACTIVITY	YES	NO	COMMENTS
2.0 Health Needs			

Cognition & Perception

Orientation	○	○	
Memory concerns	○	○	
Wandering	○	○	
Personal safety (use household appliances /emergency response/stranger treatment)	○	○	

Health Issues

Compliant with medication	○	○	
Health			
- Diabetes	○	○	
- Asthma	○	○	
- Epilepsy	○	○	
Personal injury (ability to attend to minor first aid and/or seek assistance)	○	○	
Medical (ability to recognise need for medical intervention and initiate assistance)	○	○	

Are you currently pregnant? ☐ Yes ☐ No

Administration of Medication

☐ The Client is capable of self-medicating, including ordering, receipting, storing and administering of medication

OR

☐ The Client is not capable of self-medicating and requires assistance with ordering, receipting, storing and the administration of medication including restricting access to medication.