



## Preliminary Assessment

Please help us by answering the following questions. Simply check the appropriate box(es) AND fill in.

Name of your loved one: \_\_\_\_\_

1. Any chronic health conditions:

Yes                       No

If yes, list conditions: \_\_\_\_\_

\_\_\_\_\_

8. Remembers to consistently take medications:

Independent               Needs assistance

List all medications: \_\_\_\_\_

\_\_\_\_\_

2. Eating:

Independent               Needs assistance

3. Dressing:

Independent               Needs assistance

4. Bathing:

Independent               Needs assistance

5. Using the toilet:

Independent               Needs assistance

6. Ability to move:

Independent               Needs assistance

7. Uses the following devices (check all that apply):

- Front Wheel Walker
- Pick-up Walker
- Quad Cane
- Single Point Cane
- Wheelchair
- Other device

9. Can use the phone:

Independent               Needs assistance

10. Does housework:

Independent               Needs assistance

11. Can use public transportation:

Independent               Needs assistance

12. Short-term memory is fine (able to recall after five minutes):

Yes                               No

13. Long-term memory is fine (able to recall the past):

Yes                               No

14. Able to make decisions:

Yes                               No

15. Able to communicate own needs:

Yes                               No

Your name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Click the "SUBMIT" button at the right to email your answers directly.  
Or print the completed document first, then mail or fax it to us.

**SUBMIT**

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Helping you chart a better future for your aging parents and loved ones.