Name:	**DOB/ Age:**	**PMH:**
Admit/Testing Results:		**WB Status:** **Pain:**
Precautions:		HR: / BP: / Orthostatic
Home Status: Alone Spouse/S.O. Family: Pets:		**PLOF including AD**

HR:	BP:	Orthostatic

Type of Home:	# of Steps:
Bathroom Set Up: Walk-In Tub/Shower Tub	
Activities of Daily Living	**Level of Assistance**
Feeding	
Grooming/Hygiene	
UB Dressing	
LB Dressing	
UB Bathing	
LB Bathing	
Toileting	
Functional Mobility	

ADLs:	IADLs:
History of Falls:	
Driving:	
Work:	
Leisure:	
Activity Tolerance:	

	ROM	**MMT**
Left		
Right		

Sensory Integration			**Vision**	**Cognitive Function**
Sensation	L	R	Cataracts:	Orientation: □ Person □ Place □ Time
Light Touch			Glaucoma:	Commands: □ Unable □ One-Step □ Multi-Step
Sharp/Dull			Glasses:	Memory:
Stereognosis			Last eye exam:	Safety Awareness: