**ACTIVITY ASSESSMENT**

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| --- | --- | --- | --- | --- | --- |
| Name: | | Room#: | | | Record#: |
| Preferred Name: | | Sex: M  F | | | DOB: |
| Marital Status: M  S  D  W | | If married, spouse’s name: | | | Anniversary: |
| Personal Safeguards: | | | | | |
| Impairments: Mobility (Walker/Wheelchair/Bedridden)  Eyesight  Hearing  Speech  Traumatic Brain Injury  Mental Illness Symptom Interference  Language Barrier  Dentures | | | | | |
| Dietary Restrictions: | | | | | |
| How many of Children? | | Grandchildren? | | | Great Grandchild? |
| Where were you born? | | | Where did you grow up? | | |
| Highest grade completed in school: | | | Career/Occupation? | | |
| Favorite Color: | | | Favorite Type of Music: | | |
| Favorite Hobby: | | | Play an instrument: | | |
| Favorite Sport: | | | Favorite Movie: | | |
| Favorite Game: | | | Favorite Arts & Crafts: | | |
| Favorite Food: | | | Favorite Drink: | | |
| Favorite Baked Good: | | | Favorite Snack: | | |
| Morning Routine: | | | Afternoon Routine: | | |
| Evening Routine: | | | Sleep Routine: | | |
| Birthday Tradition: | | | Special Holiday Tradition: | | |
| Cultural Tradition: | | | Religious Affiliation: | | |
| Favorite Pet: | | | Military: | | |
| Languages Spoken: | | | Places Lived: | | |
| Family/Friend in Area? | | | Can we help you vote? Yes  No  If yes, by: Absentee  Go to the polls | | |
| Does pain stop you from doing activities?  Yes  No | | |  | | |
| Anything other than pain bother you: | | | | | |
| **Activities you enjoy:** Music  Sports  Movies  Arts & Crafts  Outdoor  Aerobics  Bingo  Food Related  Mystery Themed  Reading  Pet Therapy  Gardening  Beauty  Games  Religious  Other: | | | | | |
| **Problem(s):**  Independent and attends/is interested in programs  Restricted to bed due to medical reason:  fully responsive  unable to express needs  Refuses to attend group programs  Difficulty being active in programs  Difficulty transporting self to programs  Difficulty remembering schedule of programs  Experiences increased confusion and memory loss  New to facility and needs adjustment to new environment  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Goals:** Time frame:  Less than 14 days  15 days or more  Attend at least \_\_\_\_\_\_ programs  Choose at least \_\_\_\_\_\_activities during stay  Accept 1:1 visit  Remain in program for at least \_\_\_\_\_\_\_ minutes at a time twice a day  Respond to staff as appropriate at least \_\_\_\_\_\_ per program  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Staff Intervention Plan:**  Provide therapeutic activity services and schedule to Patient & family members  Collaborate with Interdisciplinary Team  Provide 1: 1 visits  Provide and encourage recreational activities  Encourage and escort to programs  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Date: | Visited with: Patient  Family  Patient Representative | | | | |
| Other information obtained from: Medical Record  Staff  Other: | | | | | |
| Observations & Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Signature: | | | | Title: | |

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