

Nursing History and Assessment Tool

I. General Information

Client name: _____ Allergies: _____

Room number: _____ Diet: _____

Doctor: _____ Height/weight: _____

Age: _____ Vital signs: TPR/BP _____

Sex: _____ Name and phone no. of significant other: _____

Race: _____

Dominant language: _____ City of residence: _____

Marital status: _____ Diagnosis (admitting & current): _____

Chief complaint: _____

Conditions of admission:

Date: _____ Time: _____

Accompanied by: _____

Route of admission (wheelchair; ambulatory; cart): _____

Admitted from: _____

II. Predisposing Factors

A. Genetic Influences

1. Family configuration (use genograms):

Family of origin:

Present family:

Family dynamics (describe significant relationships between family members): _____

2. Medical/psychiatric history:

a. Client: _____

b. Family members: _____

3. Other genetic influences affecting present adaptation. This might include effects specific to gender, race, appearance, such as genetic physical defects, or any other factor related to genetics that is affecting the client's adaptation that has not been mentioned elsewhere in this assessment.

B. Past Experiences

1. Cultural and social history:

a. Environmental factors (family living arrangements, type of neighborhood, special working conditions): _____

b. Health beliefs and practices (personal responsibility for health; special self-care practices); _____

c. Religious beliefs and practices: _____

d. Educational background: _____

e. Significant losses/changes (include dates): _____

f. Peer/friendship relationships: _____

g. Occupational history: _____

h. Previous pattern of coping with stress: _____

i. Other lifestyle factors contributing to present adaptation: _____

C. Existing Conditions

1. Stage of development (Erikson):

a. Theoretically: _____

b. Behaviorally: _____

c. Rationale: _____

2. Support systems: _____

3. Economic security: _____

Nursing History and Assessment Tool (Continued)

4. Avenues of productivity/contribution:

- a. Current job status: _____

- b. Role contributions and responsibility for others: _____

III. Precipitating Event

Describe the situation or events that precipitated this illness/hospitalization: _____

IV. Client's Perception of the Stressor

Client's or family member's understanding or description of stressor/illness and expectations of hospitalization: _____

V. Adaptation Responses

A. Psychosocial

1. Anxiety level (circle level, and check the behaviors that apply): mild moderate severe panic
calm _____ friendly _____ passive _____ alert _____ perceives environment correctly _____
cooperative _____ impaired attention _____ "jittery" _____ unable to concentrate _____
hypervigilant _____ tremors _____ rapid speech _____ withdrawn _____ confused _____
disoriented _____ fearful _____ hyperventilating _____ misinterpreting the environment (hallu-
cinations or delusions) _____ depersonalization _____ obsessions _____ compulsions _____
somatic complaints _____ excessive hyperactivity _____ other _____

2. Mood/affect (circle as many as apply): happiness sadness dejection despair elation
euphoria suspiciousness apathy (little emotional tone) anger/hostility

3. Ego defense mechanisms (describe how used by client):

Projection _____
Suppression _____
Undoing _____
Displacement _____
Intellectualization _____
Rationalization _____
Denial _____
Repression _____
Isolation _____
Regression _____
Reaction Formation _____
Splitting _____
Religiosity _____
Sublimation _____
Compensation _____

4. Level of self-esteem (circle one): low moderate high

Things client likes about self _____

Things client would like to change about self _____

Objective assessment of self-esteem:

Eye contact _____

General appearance _____

Personal hygiene _____

Participation in group activities and interactions with others _____

5. Stage and manifestations of grief (circle one):

denial anger bargaining depression acceptance

Describe the client's behaviors that are associated with this stage of grieving in response to loss or change. _____

6. Thought processes (circle as many as apply): clear logical easy to follow relevant confused

blocking delusional rapid flow of thoughts slowness in thought association suspicious

Recent memory (circle one): loss intact Remote memory (circle one): loss intact

Other: _____

7. Communication patterns (circle as many as apply): clear coherent slurred speech incoherent

neologisms loose associations flight of ideas aphasic perseveration rumination

tangential speech loquaciousness slow, impoverished speech

speech impediment (describe) _____

other _____

8. Interaction patterns (describe client's pattern of interpersonal interactions with staff and peers on the unit, e.g., manipulative, withdrawn, isolated, verbally or physically hostile, argumentative, passive, assertive, aggressive, passive-aggressive, other): _____

9. Reality orientation (check those that apply):

Oriented to: time _____ person _____

 place _____ situation _____

10. Ideas of destruction to self/others? Yes No

If yes, consider plan; available means _____

Nursing History and Assessment Tool (Continued)

B. Physiological

1. Psychosomatic manifestations (describe any somatic complaints that may be stress-related): _____

2. Drug history and assessment:

Use of prescribed drugs:

NAME	DOSAGE	PRESCRIBED FOR	RESULTS
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Use of over-the-counter drugs or herbal supplements:

NAME	DOSAGE	USED FOR	RESULTS
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Use of street drugs or alcohol:

NAME	AMOUNT USED	HOW OFTEN USED	WHEN LAST USED	EFFECTS PRODUCED
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. Pertinent physical assessments:

a. Respirations: normal _____ labored _____

Rate _____ Rhythm _____

b. Skin: warm _____ dry _____ moist _____ cool _____ clammy _____ pink _____

cyanotic _____ poor turgor _____ edematous _____

Evidence of: rash _____ bruising _____ needle tracts _____ hirsutism _____

loss of hair _____ other _____

c. Musculoskeletal status: weakness _____ tremors _____

Degree of range of motion (describe limitations) _____

Pain (describe) _____

Skeletal deformities (describe) _____

Coordination (describe limitations) _____

d. Neurological status:

History of (check all that apply): seizures _____ (describe method of control) _____

headaches (describe location and frequency) _____
fainting spells _____ dizziness _____
tingling/numbness (describe location) _____

e. Cardiovascular: B/P _____ Pulse _____

History of (check all that apply):

hypertension _____ palpitations _____
heart murmur _____ chest pain _____
shortness of breath _____ pain in legs _____
phlebitis _____ ankle/leg edema _____
numbness/tingling in extremities _____
varicose veins _____

f. Gastrointestinal:

Usual diet pattern: _____
Food allergies: _____
Dentures? Upper _____ Lower _____
Any problems with chewing or swallowing? _____
Any recent change in weight? _____
Any problems with:
indigestion/heartburn? _____
relieved by _____
nausea/vomiting? _____
relieved by _____
History of ulcers? _____
Usual bowel pattern _____
Constipation? _____ Diarrhea? _____
Type of self-care assistance provided for either of the above problems _____

g. Genitourinary/Reproductive:

Usual voiding pattern _____
Urinary hesitancy? _____ Frequency? _____
Nocturia? _____ Pain/burning? _____
Incontinence? _____
Any genital lesions? _____
Discharge? _____ Odor? _____
History of sexually transmitted disease? _____
If yes, please explain _____

(Continued)

Nursing History and Assessment Tool (Continued)

Any concerns about sexuality/sexual activity? _____

Method of birth control used _____

Females:

Date of last menstrual cycle _____

Length of cycle _____

Problems associated with menstruation? _____

Breasts: Pain/tenderness? _____

Swelling? _____ Discharge? _____

Lumps? _____ Dimpling? _____

Practice breast self-examination? _____

Frequency? _____

Males:

Penile discharge? _____

Prostate problems? _____

h. Eyes:	YES	NO	EXPLAIN
Glasses?	_____	_____	_____
Contacts?	_____	_____	_____
Swelling?	_____	_____	_____
Discharge?	_____	_____	_____
Itching?	_____	_____	_____
Blurring?	_____	_____	_____
Double vision?	_____	_____	_____

i. Ears	YES	NO	EXPLAIN
Pain?	_____	_____	_____
Drainage?	_____	_____	_____
Difficulty hearing?	_____	_____	_____
Hearing aid?	_____	_____	_____
Tinnitus?	_____	_____	_____

j. Medication side effects:
What symptoms is the client experiencing that may be attributed to current medication usage?

k. Altered lab values and possible significance: _____

l. Activity/rest patterns:
Exercise (amount, type, frequency) _____

Leisure time activities: _____

Patterns of sleep: Number of hours per night _____

Use of sleep aids? _____

Pattern of awakening during the night? _____

Feel rested upon awakening? _____

m. Personal hygiene/activities of daily living:

Patterns of self-care: independent _____

Requires assistance with: mobility _____

hygiene _____

toileting _____

feeding _____

dressing _____

other _____

Statement describing personal hygiene and general appearance _____

n. Other pertinent physical assessments: _____

VI. Summary of Initial Psychosocial/Physical Assessment:

Knowledge Deficits Identified:

Nursing Diagnoses Indicated:

SOURCE: From Townsend (2003)

From Townsend, Essentials of Psychiatric and Mental Health Nursing, 3/e. FA Davis, 2005