COBALT HEALTH CARE @ REHABILITATION CENTER
NEW RESIDENT ASSESSMENT

In order for Cobalt Health Care staff to appropriately care for each resident, knowing about their individual needs is essential. We ask that you complete the following questions to the best for your ability. All information is regarded as strictly confidential. Please consider only the previous years' experience when answering the questions.

Does he/she stay up late at night, after 9PM? Y__ N__

What time do he/she normally wake-up in the morning? ________

Does he/she nap regularly during the day, at least one (1) hour? Y__N__

Does he/she go outside, leave the house, one or more days per week? Y__N__
How Often? __________________________________

Does he/she like to stay busy with hobbies, reading, or a fixed daily routine?
Y__N__
What/How?____________________________________
____
____

Does he/she spend most of their time alone or watching TV?
Y__N__

Does he/she move independently thought out the home? Y__N__

Does he/she use tobacco products daily? Y__N__

Does he/she remain in bedclothes most of the day? Y__N__

Does he/she get up in the night to go to the bathroom? Y__N__
How often?___________________________________

Does he/she have irregular bowel movements? Y__N__

Is he/she incontinent of either urine or feces? Y__N__
Which? _____________________________________

Does he/she bath or shower independently? Y__N__
How often? ______________________________

Does he/she like to bathe or shower in the morning or evening? AM__PM__

Does he/she use alcoholic beverages at least weekly? Y__N__
How often? ____________ Type?___________

What distinct food preferences does he/she have?
____

What foods does he/she dislike?
____

Is he/she allergic to any foods?
____

Deso he/she have any special diet restrictions?
____

Does he/she eat between meals most days?
____

Does he/she have daily contact with relatives or close friends? Y__ N__
How often do he/she have contact? _________________

Does he/she attend worship services? Y__N__ What faith? _________________

Does he/she have pets? Y__N__ What kind? _________________
What kind? __________________

Does he/she participate in social/group activities? Y__ N__

What type(s)? ____

____
____

What are his/her favorite activities?

____
____
____
____

What type of music or radio programs Does he/she like to listen to?

____
____

Do they have a hearing aid? Y__ N__

When was it last tested?__________________

Do they were glasses? Y__ N__

When were they last checked? ____________

Do they wear dentures? Y__ N__

When were they lasted fitted? ____________

Type? _____________