Department of Veterans Service

Floyd Veterans Memorial Building, Suite E-970
Atlanta, GA 30334-4800

APPLICANT ACTIVITIES OF DAILY LIVING SURVEY FORM

This survey form is needed by the Admission Screening Committee to more accurately evaluate the amount and type of care needed by the applicant. **PLEASE CHECK THE APPROPRIATE ANSWER FOR EACH ITEM.** Incomplete or unsigned forms will delay processing of the application.

BEHAVIORS:

Alert/Aware	YES ☐	NO ☐
Hostile Physically (Fights)	YES ☐	NO ☐
Yells	YES ☐	NO ☐
Wanders	YES ☐	NO ☐
Comatose (Unconscious)	YES ☐	NO ☐
Cooperative	YES ☐	NO ☐

WALKING:

Walks by self	YES ☐	NO ☐
Uses cane or walker	YES ☐	NO ☐
Uses wheelchair	YES ☐	NO ☐
Stays in bed or chair	YES ☐	NO ☐
Falls frequently	YES ☐	NO ☐

MOVEMENT FROM BED TO CHAIR/TOILET:

Moves by self	YES ☐	NO ☐
Has to be carried or helped	YES ☐	NO ☐
Shifts weight in chair by self	YES ☐	NO ☐
Turns self in bed	YES ☐	NO ☐
Able to use nurse call button	YES ☐	NO ☐

EXERCISE OF LIMBS:

Moves arms by self	YES ☐	NO ☐
Moves legs by self	YES ☐	NO ☐
Receives physical therapy	YES ☐	NO ☐

DRESSING:

Dresses upper body by self	YES ☐	NO ☐
Dresses lower body by self	YES ☐	NO ☐
Puts on socks and shoes by self	YES ☐	NO ☐
Receives occupational therapy	YES ☐	NO ☐

BATHING:

Needs bed bath given	YES ☐	NO ☐
Takes tub bath by self	YES ☐	NO ☐
Takes shower by self	YES ☐	NO ☐
Resists bathing	YES ☐	NO ☐

EATING:

Feeds self	YES ☐	NO ☐
Feeding tube	YES ☐	NO ☐
Eats complete meal	YES ☐	NO ☐

Diet type (specify): _____

GROOMING:

Shaves self	YES ☐	NO ☐
Brushes own teeth/dentures	YES ☐	NO ☐
Trims own nails	YES ☐	NO ☐

TOILETING:

Bowel control	YES ☐	NO ☐
Bladder control	YES ☐	NO ☐
Urinary catheter (tube in bladder)	YES ☐	NO ☐
Colostomy (hole in abdomen)	YES ☐	NO ☐
Ileostomy (tube in bladder)	YES ☐	NO ☐

SKIN CONDITION:

Dry skin	YES ☐	NO ☐
Bruises easily	YES ☐	NO ☐
Skin tears easily	YES ☐	NO ☐
Rash on body	YES ☐	NO ☐

Bedsores: How many? Where? _____

BREATHING STATUS:

Uses oxygen tanks/concentrator	YES ☐	NO ☐
Tracheostomy (hole in throat)	YES ☐	NO ☐
Needs suctioning	YES ☐	NO ☐
Can cough	YES ☐	NO ☐
Smokes/chews tobacco	YES ☐	NO ☐

SENSES:

Poor vision	YES ☐	NO ☐
Blind	YES ☐	NO ☐
Wears glasses/contacts	YES ☐	NO ☐
Deaf	YES ☐	NO ☐
Wears hearing aid	YES ☐	NO ☐
Can talk/communicate	YES ☐	NO ☐

OTHER:

Needs safety devices	YES ☐	NO ☐
Dentures	YES ☐	NO ☐
Artificial limbs or braces	YES ☐	NO ☐
Legal Guardian	YES ☐	NO ☐
Power of Attorney (POA)	YES ☐	NO ☐
Living Will	YES ☐	NO ☐
Durable POA for Healthcare	YES ☐	NO ☐
Georgia Advance Directive for Health Care	YES ☐	NO ☐

1. Do you now, or have you ever had a problem with alcohol? YES ☐ NO ☐

Explain. _____

_____

2. Have you ever been hospitalized for alcoholism or related illness? YES ☐ NO ☐

Explain. _____

_____

_____

3. Do you now or have you ever had a problem with illicit drugs (marijuana, cocaine, etc.)? YES ☐ NO ☐

Explain. _____

_____

4. Has applicant ever been treated for a psychiatric (mental) illness? YES ☐ NO ☐

Explain. (Diagnosis, Where, When) _____

_____

_____

5. Is applicant currently participating in any experimental research therapy program? YES ☐ NO ☐

Explain. _____

_____

Additional comments (describe daily routine, personality, habits, likes/dislikes, etc.):

_____

_____

_____

_____

Name: _____ _____

Signature

Relationship to applicant: _____ Date: _____

Please return this form with your application. **FALSIFICATION OF INFORMATION MAY RESULT IN THE APPLICANT BEING DENIED ADMISSION OR DISCHARGED FROM THE NURSING HOME.**