



Adult Nursing Assessment and Care Plan Form

Student's Name: _____ **Student's No.** _____
Semester/year: _____ **Departments:** _____
Training from: _____ **to** _____ **Total Training Days/hours :** _____
Student Mark: _____ **Clinical instructor:** _____

Initial name: _____ **Age:** _____ **Gender :** _____ **Admission date:** _____
Marital status: _____ **Employment:** _____ **Education level** _____ **Smoking status** _____

Chief complaint:

Confirmed diagnosis:

- Past Medical history

.....

- Previous surgeries

.....

- Family history

.....

Functional Health Patterns Assessment (Adult)

1. Health Perception Health Management Pattern

a. How is the family's health?.....

.....

b. What important things you do to keep healthy? Include family traditional medicines when appropriate.)

.....

.....

b. Do you follow suggestions from physicians or nurses?

.....

c. Do you have regular check-ups with your physician or specialist? If yes, specify.....
.....

2. **(Objective Data)** Examination—General health appearance

.....
.....

2. NUTRITIONAL-METABOLIC PATTERN

a. Typical daily food intake? (Describe.) Supplements (vitamins, type of snacks)?

.....
.....

b. Typical daily fluid intake? (Describe.).....

c. Weight loss or gain last 6 months? Yes No (Amount.....) ,

Height loss or gain? Yes No (Amount)

d. Appetite? Good normal poor

e. Food or eating: Diet restrictions (Describe.).....

Discomfort? Nausea Yes No , Vomiting Yes No, Stomatitis Yes No, Dysphagia Yes No

Healing? Well Poorly , Skin problems: Lesions Dryness

h. Dental problems: Dentures Partial

2. **(Objective Data)** Examination:

a. **Skin:** Bony prominences? Yes No, Lesions Yes No , Color changes? Yes No, Moistness Yes No, Edema Yes No

b. Oral mucous membranes: Color changes? Yes No Moistness? Yes No, Lesions? Yes No

c. Teeth: General appearance and alignment?

Cavities? Yes No, Missing teeth? Yes No

d. Actual weight,.....Kg , height..... cm, e. Temperature.....C°

f. Intravenous feeding—parenteral feeding (specify)? Yes No

3. ELIMINATION PATTERN

1. History

a. **Bowel elimination pattern?** (Describe).....

Frequency?.....

Discomfort? Constipation No Yes(Describe).....

Diarrhea No Yes (Describe)..... Incontinency No Yes

Bleeding No Yes(Describe).....Painful defecation Yes No

Ostomy No Yes (Describe).....

Using of laxatives ? No Yes (Describe).....

b. **Urinary elimination pattern?** (Describe.).....

Frequency?

Problem in control?

Retention Yes No, Hematuria Yes No, Dysuria Yes No, Urgency Yes No,

Incontinency Yes No, Nocturia Yes No, Anuria Yes No, Burning Yes No

Assistive devices : No external condom folly's catheter umbilical cath.

c. Excessive perspiration (sweat)? Odor problems? Yes No

2. **(Objective Data) Examination** : Bowel sounds : Present No Yes , Distention Yes No, Tenderness

Yes No, Masses : No Yes(describe),

4. ACTIVITY-EXERCISE PATTERN

1. History

a. Sufficient energy for desired or required activities? Yes No

b. Exercise pattern? Regularity?

c. Perceived ability (use codes : 1= independent, 2 = needs assistance, 3 = dependent)

Feeding BathingToileting Dressing.....Grooming.....Bed mobility.....

General mobility..... Shopping..... Cooking..... Home maintenance.....

2. (Objective Data) Examination:

A- Range of motion : Full Yes No. , Other (specify)

B- Balance and gait : Steady Yes No

C- Hand Grasps : Equal Yes No, Strong Yes No,

Weakness: Rt Yes No, Lt Yes No. Paralysis: Rt Yes No, Lt Yes No

D- Leg muscles : Equal Yes No, Strong Yes No,

Weakness: Rt Yes No, Lt Yes No. Paralysis: Rt Yes No, Lt Yes No

5. SLEEP-REST PATTERN

1. History

a. Generally rested and ready for daily activities after sleep?

b. Sleep onset problems? No Yes, Aids? No Yes (specify)

Dreams (nightmares)? Yes No, Early awakening? Yes No

c. Rest-relaxation periods? No Yes, from..... to, total hours

6. COGNITIVE-PERCEPTUAL PATTERN

1. History

a. Hearing difficulty? No Yes, Hearing aid? Yes No, Tinnitus Yes No

b. Vision

Wear glasses /lenses? No Yes, Last checked?

When last changed?

c. Any change in memory lately? Yes No

d. Important decision easy to make? Yes easy to make No it is difficult

e. Any discomfort? Yes No

Pain? Yes No Pain severity by (pain scale 1-10).....

When appropriate: How do you manage it?

2. (Objective Data) Examination

- a. Orientation. Persons Time Place
- b. Hears whisper? Yes No
- c. Reads newspaper? Yes No
- d. Grasps ideas and questions (abstract, concrete)?
- e. Language spoken.
- f. Attention span.

7. SELF-PERCEPTION—SELF-CONCEPT PATTERN

1. History

- a. How describe self? Most of the time, feel good (not so good) about self?
.....
- b. Changes in body or things you can't do? Problem to you?
.....
- c. Changes in way you feel about self or body (since illness started)?
.....
- d. Things frequently make you angry? Yes No
 - Annoyed? Yes No, Fearful? Yes No, Anxious? Yes No
- e. Ever feel you lose hope? Yes No

2. **(Objective Data)** Examination

- a. Eye contact Yes No, Attention span (distraction) Yes No
- b. Voice and speech pattern. normal abnormal
- c. Nervous (5) or relaxed (1); rate from 1 to 5. **Client rate**
- d. Assertive (5) or passive (1); rate from 1 to 5. **Client rate**

8. ROLES-RELATIONSHIPS PATTERN

1. History

- a. Live alone? No Yes, Live with Family? Yes No, Family members?.....
- b. Any family problems you have difficulty handling (nuclear or extended)?
.....

c. Family or others depend on you for things? How managing?

.....

d. When appropriate: How family or others feel about illness or hospitalization?

.....

e. When appropriate: Problems with children? Difficulty handling?

.....

f. Belong to social groups? Close friends? Feel lonely (frequency)?

.....

g. Things generally go well at work? (School?)

.....

h. Feel part of (or isolated in) neighborhood where living?

.....

2. Examination

a. Interaction with family member(s) or others (if present).

9. SEXUALITY-REPRODUCTIVE PATTERN

1. History

a. When appropriate to age and situations: Sexual relationships satisfying?

Changes? Yes No Problems?.....

b. When appropriate: Use of contraceptives? Yes No Problems? Yes No

.....

c. Female: When menstruation started?

Last menstrual period?Menstrual problems? Yes No

Gravida?.....Para?.....Abortion?

Vaginal bleeding / discharge Yes No

2. **(Objective Data)** Examination

a. None unless problem identified or pelvic examination is part of full physical assessment.

10. COPING-STRESS TOLERANCE PATTERN

1. History

a. Any big changes in your life in the last year or two? Crisis?

.....

b. Tense or relaxed most of the time? When tense, what helps?

.....

c. Use any medicines, drugs, alcohol?

.....

d. Coping mechanisms.....

.....

2. **(Objective Data)** Examination: None.

11. VALUES-BELIEFS PATTERN

1. History

a. Generally get things you want from life? Yes No, Important plans for the future? Yes No

b. Religion important in life? Yes No

When appropriate: Does this help when difficulties arise? Yes No

c. When appropriate: Will being here interfere with any religious practices? Yes No

Other Physical Examination (Objective Data)

Respiratory / Circulatory

A- Blood Pressure

B- Pulse : Apical rate , Radial rate Rhythm

Heart auscultation : Abnormal sound No Yes(Specify)

.....

C- Respiration : Rate -----, Rhythm -----

Lung auscultation : Abnormal sounds No Yes(Specify)

Medication Profile

Drug and Classification	For this patient Indications	Dose Frequency	Contraindications	Expected side effects	Nursing Implication

Laboratory and Diagnostic Tests

Date	Performed Test	Normal Value	Patient's Value	Interpretations
	Last CBC	Hgb.		
		HCT		
		RBCS		
		WBCS		
		PLT		
	Last S. electrolyt	Na		
		K		
		Ca		
	KFT	Urea		
		<i>Creatinine</i>		

Date	Performed Test	Normal Value	Patient's Value	Interpretations	
	Others				

Radiologic studies

X-ray: No Yes(Specify, organ and result)

.....

CT: No Yes(Specify, organ and result)

.....

MRI: No Yes(Specify, organ and result)

.....

Ultrasound: No Yes(Specify, organ and result)

.....

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.....

Nursing Care Plan (1)

Functional Health Pattern

Nursing Problem

Actual Nursing Diagnosis

Evidenced By

Short - Term Goals

.....

Planned intervention with Rationale

1.

Rational/

2.

Rational/

3.

Rational/

4.

Rational/

5.

Rational/

Actual Intervention

1.

2.

3.

4.

Evaluation of outcomes

.....

Nursing Care Plan (2)

Functional Health Pattern

Nursing Problem

Actual Nursing Diagnosis

Evidenced By

Short - Term Goals

.....

Planned intervention with Rationale

6.

Rational/

7.

Rational/

8.

Rational/

9.

Rational/

10.

Rational/

Actual Intervention

5.

6.

7.

8.

Evaluation of outcomes

.....

Nursing Care Plan (3)

Functional Health Pattern

Nursing Problem

Potential Nursing Diagnosis

Evidenced By

Short - Term Goals

.....

Planned intervention with Rationale

11.

Rational/

12.

Rational/

13.

Rational/

14.

Rational/

15.

Rational/

Actual Intervention

9.

10.

11.

12.

Evaluation of outcomes

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