University of Babylon/College of Nursing

Family and Community Health Nursing/Geriatric Nursing

Elderly Mental Health Assessment

1- Identification data

Name of the client _____ Age_____ years
Gender _____ house no. _____
Address_____
Education _____
Occupation_____
Marital status: single / married / widow / divorce
Family: nuclear/joint

Date of starting the study ____/____/_____
Date of completion the study ___/___/_____

A- Physical assessment:

Walk alone: yes/no
Needs assistance by:
Person yes/no
Walker yes/no
Wheel chair yes/no
Degree of ambulation: _____
Complete bed rest yes/no

B- Assessment of sensory condition

Sense	Sensory condition		
	normal	Impaired	Others
1- hearing			Using aids
2- vision			Wearing glass
3- touch			
4- taste			
5- smell			

C- Ability to perform activities of daily livings (ADLs)

Activities	Ability to care for himself		
	Independent	Partially dependent	Totally dependent
1- Eating			
2- Dressing			
3- Combing			
4- Morning care (toileting)			
5- Bathing			

D- Diet of the elderly

Diet: **a)** Ordinary **b)** special

Nutritional Habits and problems

Habits/problems	yes	No
1- anemia		
2- anorexia		
3- denture problem		
4- digestive problem		
5- tea/coffee		
6- smoking habit		
7- other problems		

E- Special complains now

complaints	yes	No
1- Inability to care for oneself		
2- Insomnia		
3- Headache		
4- General pain		
5- arthritis		
6-others		

F- Psychological assessment:

Complaints	Yes	No
1- is your daily life full of things that keep you interested		
2- not able to adjust to life		
3- have you at sometimes wanted very much to leave home		
4- always live in the past		
5- does it seem that no one understands you		
6- do you feel weak all over much of the time		
7- feels lonely		
8- depressed		
9- is your sleep disturbed		
10- others		

G- Social assessment:

1- concentration :
2- Special hobbies and interest : walking/reading/ painting/ drawing / playing Dominos

H- Social support system

Visit of the family members and friends to the elderly in the home

Family yes/no
Friends yes/no
Relatives yes/no

Who lives with you? _____

Have you talked to any friends or relatives on phone recently?
Yes/ no

Are you satisfied by seeing your friends or relatives often you want?
Yes/no

Is there someone who would care for you?
Yes / no

2- Mental status assessment

A- General appearance (please check where applies)

Posture: slouched _____ rigid_____

Dress: inappropriate for place or weather _____

Grooming: meticulous ____un-kept ____poor hygiene____

B- Non- verbal communication:

Angry facial expression_____

Restless _____

Agitated_____

Lack of eye contact_____

C- General behavior:

Tense _____ resentful /hostile_____

Unwilling to participate in care / uncooperative

3-Mood:

Tearful _____ Elated_____

Sudden mood changes _____ flat affect ___

4-Speech/language

Slow _____ monotonous ____ rapid nonstop_____

Discuss in appropriate topic ____ flight of ideas_____

Incoherent garbled _____ disorganized _____

5- Orientation (level of awareness)

Unaware of time: _____

Unaware of place _____

Unaware of: self /others / circumstances

6- State of consciousness

Slow movements and delayed response to stimuli _____

Respond only to vigorous stimuli _____

No response to stimuli_____

7- Memory:

No recall of recent memory ----------

No recall of past _____

8- Information or knowledge level

Distorted perception of cause of the problem_____

Lack of understanding of reason for treatment _____

Poor comprehension of required skill_____

Denial of the problem or need treatment _____

Client / family needs / problems (state as nursing diagnosis)

_____
_____
_____
_____
_____
_____
_____