

VIRGINIA PHYSICAL ASSESSMENT

Last Name First MI

SSN: _____ Medicaid #: _____

1. Vital signs

a. Height in inches: _____ b. Weight _____ c. Frame: Small Medium Large

d. BP _____ Pulse _____ Respiratory rate _____

e. Stability of the individual's condition: Improving Stable Deteriorating Unstable

2. Medications:

Dosage:

Purpose:

3. Neurological Assessment:

Coding

Y=Yes

N=No

U=Uncooperative

a. Motor functioning

Y N U

- Can reach for and lift an object
- Can brush/comb own hair
- Can stand up straight
- Abnormal involuntary movements

c. Visual sensory functioning

Y N U

- Pupils equal
- Pupils follow lateral movement
- Pupils react to light
- Nystagmus present

e. Cranial nerves

Y N U

- Masseters tighten with jaw clenched
- Able to feel touch on face
- Able to smile and say "E"
- Mouth deviates to L/R when smiling

b. Fine motor skills

Y N U

- Can pick up pencil/pen
- Can button shirt
- Can tie shoe string
- Able to appreciate touch

d. Oral sensory functioning

Y N U

- Tongue deviates to L/R
- Stridor/hoarseness/dysarthria present
- Uvula is central
- Abnormal involuntary movement
- Pharyngeal muscles contract

f. Eye/hand coordinator

Y N U

- Can touch nose with finger
- Can touch assessors extended index finger
- Can catch an object
- Can copy a circle/square

VIRGINIA PHYSICAL ASSESSMENT (Continued)**g. Spine and Peripheral nerves**

Y N U

- Neck is supple
 Spinal curvatures are normal
 Able to shrug shoulder against resistance
 Able to turn neck against resistance

h. Gait

Y N U

- Normal
 Wide-stepping
 Shuffling
 Paretic

I. Normal reflexes left side

Y N U

- Tricep joint
 Bicep joint
 Wrist joint
 Knee Joint
 Achilles joint
 Plantars

j. Normal reflexes right side

Y N U

- Tricep joint
 Bicep joint
 Wrist joint
 Knee joint
 Achilles joint
 Plantars

4. Review of Systems Mark the "Yes" or "No" box as indicated by the individual, staff, or chart review, if the individual is experiencing the following problems. Please indicate source of information.

a. Neurological problems? No Yes

- Headaches Migraines Seizures/Spells Tremors
 Dizziness Blackouts/Fainting Unsteady balance/gait Numbness

Comments: _____

b. Vision problems? No Yes

- Blurred vision Double vision Lights/Spots Field cut
 Vision loss Unequal pupils Reading small print Corrected with glasses

Comments: _____

c. Hearing problems? No Yes

- Hearing others Hearing in groups Hearing whispers Pain in ears Corrected with aid/device

Comments: _____

d. Nose problems? No Yes

- Nasal congestion Frequent runny nose Decreased ability to smell Nose bleeds

Comments: _____

e. Mouth problems? No Yes

- Gums bleed/sore Loose teeth Tooth decay Teeth missing
 Dry mouth Corrected with aid/device

Comments: _____

f. Throat/Neck problems? No Yes

- Frequent sore throats Choking episodes Difficulty swallowing Lump in throat

Comments: _____

VIRGINIA PHYSICAL ASSESSMENT (Continued)

- o. **Skin problems?** No Yes
- Rash Dry skin Fragile skin Itching
 Change in freckle/mole Pressure sore Stasis ulcer

Comments: _____

- p. **Endocrine Problems?** No Yes
- Excessive thirst Excessive hunger Cold sensitivity Diabetic

Comments: _____

5. Special Treatments

a. Please indicate which of the following special medical treatments the individual currently receives (mark all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Catheterization care | <input type="checkbox"/> Intake and output | <input type="checkbox"/> Therapeutic diets |
| <input type="checkbox"/> Colostomy care (Ileostomy) | <input type="checkbox"/> Medication monitoring | <input type="checkbox"/> Tube feedings |
| <input type="checkbox"/> Decubitus care | <input type="checkbox"/> Oral suction | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Fracture care | <input type="checkbox"/> Prosthesis care TPR/BP | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Gastrostomy | <input type="checkbox"/> Special skin care | |
| <input type="checkbox"/> Inhalation therapy | <input type="checkbox"/> Sterile dressings | |

b. Please indicate if the individual currently receives any of the following restorative nursing services:

- | | | | | | |
|---------------------------------|---------------------------------------|---------------------------------------|--|---|-------|
| <input type="checkbox"/> None | <input type="checkbox"/> Walking | <input type="checkbox"/> Transferring | <input type="checkbox"/> Dressing | <input type="checkbox"/> Bathing | _____ |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Bed mobility | <input type="checkbox"/> Grooming | <input type="checkbox"/> Bladder/Bowel | <input type="checkbox"/> Other (specify): | |

Comments: _____

PHYSICIAN SIGN-OFF

Print name: _____ Signature: _____ Date: _____
 Address: _____ City: _____ Zip: _____ Phone: _____

