Country Style
Adult Day Care

Client Health Exam

Name: _____ Date: _____

DOB:_____

*Diagnosis:*_____

Vital Signs:

Temperature_____ Pulse_____ Blood Pressure_____

Dietary Needs:_____

Any known allergies: _____

Functional Status: Independent Needs Assistance Unable To Do

Use of Toilet -_____

Dressing - _____

Mobility - _____

Walking - _____

Wheelchair - _____

Stair Climbing - _____

Medications Including OTC:

Dose	Time of Day Taken	AM	PM	Both
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		

Signature of License Practitioner:_____