Community Health Nursing Assessment Form

Comprehensive assessment tool for individuals and families

1. Client Demographics

Date of Assessment
mm/dd/yyyy

Case ID/Reference Number

Full Name
Client's full name

Date of Birth
mm/dd/yyyy

Age

Gender
Select

Contact Number
Phone number

Email
Email address

Address
Street Address
City | State/Province | ZIP/Postal Code

Emergency Contact
Name | Phone number
Relationship to client

2. Family Composition

Family Type
☐ Nuclear ☐ Extended ☐ Single-parent ☐ Blended ☐ Other

Family Members

Name	Age	Relationship	Occupation/School	Health Status

Family Structure Notes
Notes on family composition, roles, responsibilities, etc.

3. Health History

Past Medical History
☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ Cancer
☐ Stroke ☐ Asthma ☐ Mental Health Issues ☐ Other
Details of medical history

Family History
Relevant family health history

Current Medications

Medication Name	Dosage	Frequency	Purpose

Allergies
List all allergies (medications, food, environmental) and reactions

Immunization Status

Immunization	Date Received	Due Date
COVID-19	mm/dd/yyyy	mm/dd/yyyy
Influenza	mm/dd/yyyy	mm/dd/yyyy
Tetanus/Tdap	mm/dd/yyyy	mm/dd/yyyy
Other	mm/dd/yyyy	mm/dd/yyyy

4. Physical Assessment

Vital Signs
Blood Pressure (mmHg) | Heart Rate (bpm) | Respiratory Rate (bpm) | Temperature (°C/°F)
e.g., 120/80 | e.g., 37°C/98.6°F
Weight (kg/lb) | Height (cm/in) | BMI | Oxygen Saturation (%)

Systems Review

General Appearance

Skin

HEENT (Head, Eyes, Ears, Nose, Throat)

Respiratory

Cardiovascular

Gastrointestinal

Musculoskeletal

Neurological

Child Growth & Development Assessment (For Children)
Developmental Milestones
Motor Skills | Language Development
Cognitive Development | Social/Emotional Development

Growth Charts
Weight-for-Age Percentile | Height-for-Age Percentile | BMI-for-Age Percentile

Functional Assessment (For Elderly)
Activities of Daily Living (ADL)
Bathing, dressing, toileting, transferring, continence, feeding
Instrumental Activities of Daily Living (IADL)
Using phone, shopping, preparing food, housekeeping, laundry, transportation, managing medications, finances

Mobility Assessment
Gait, balance, use of assistive devices

Cognitive Assessment
Memory, orientation, judgment

5. Family Dynamics

Communication Patterns
Describe the communication patterns within the family

Decision-making Process
How are decisions made within the family?

Family Roles and Responsibilities
Describe roles and responsibilities of family members

Family Stressors and Coping Mechanisms
Identify current stressors and how the family copes with them

Family Strengths and Resources
List family strengths and available resources

6. Home Environment Assessment

Housing Type
☐ House ☐ Apartment ☐ Mobile Home ☐ Shelter ☐ Other
If other, please specify

Safety Assessment

Safety Concern	Yes	No	Notes
Adequate lighting	☐	☐	
Smoke detectors	☐	☐	
Trip/fall hazards	☐	☐	
Safe food storage	☐	☐	
Clean water supply	☐	☐	
Adequate heating/cooling	☐	☐	
Accessibility issues	☐	☐	
Safe medication storage	☐	☐	

Living Conditions
Cleanliness, organization, space adequacy, etc.

Neighborhood Safety
Assessment of neighborhood conditions and safety concerns

7. Community Resources

Access to Healthcare
Primary Care Provider | Last Visit Date
Name and contact information | mm/dd/yyyy

Healthcare Facilities Available
List of healthcare facilities accessible to the client/family

Barriers to Healthcare Access
Transportation, financial, cultural, etc.

Social Support Network
Family, friends, community organizations providing support

Educational Resources
Schools, educational programs, libraries, etc.

Financial Resources
☐ Employment ☐ Insurance ☐ Social Security ☐ Disability ☐ Public Assistance ☐ Other
Details of financial resources and concerns

Community Services Used
Current community services being utilized

Additional Community Resources Needed
Resources needed but not currently accessing

8. Health Promotion and Prevention

Health Behaviors

Nutrition	Dietary patterns, concerns, etc.
Physical Activity	Exercise habits, limitations
Sleep Patterns	Hours of sleep, quality, issues
Substance Use	Tobacco, alcohol, other substances

Screenings and Preventive Care

Screening/Preventive Care	Date Completed	Results	Next Due
Blood Pressure Screening	mm/dd/yyyy		mm/dd/yyyy
Cholesterol Screening	mm/dd/yyyy		mm/dd/yyyy
Cancer Screening	mm/dd/yyyy		mm/dd/yyyy
Diabetes Screening	mm/dd/yyyy		mm/dd/yyyy
Other	mm/dd/yyyy		mm/dd/yyyy

Health Education Needs
Areas requiring health education

9. Assessment Summary and Plan

Identified Problems/Needs
1. Problem/Need #1
2. Problem/Need #2
3. Problem/Need #3
4. Problem/Need #4
5. Problem/Need #5

Nursing Diagnoses
1. Nursing Diagnosis #1
2. Nursing Diagnosis #2
3. Nursing Diagnosis #3

Goals/Expected Outcomes
1. Goal/Outcome #1
2. Goal/Outcome #2
3. Goal/Outcome #3

Interventions/Referrals
Planned nursing interventions and referrals to address identified needs

Follow-up Plan
Next Visit Date | Follow-up Type
mm/dd/yyyy | Select
Follow-up Details
Specific follow-up actions and focus areas

10. Authentication

Nurse's Name (Print) | **Credentials**

Nurse's Signature | **Date**
mm/dd/yyyy

Client/Guardian Name (Print)

Client/Guardian Signature (Acknowledging assessment was performed)

Date
mm/dd/yyyy