Health Promotion and the Individual

Gordon’s Functional Health Patterns Assessment (Adult)

Health Perception Health Management Pattern

1. History
   a. How has general health been?
   b. How has general health been?
   c. How has general health been?
   d. How has general health been?
   e. How has general health been?
   f. How has general health been?
   g. How has general health been?

2. Examination—general health appearance

NUTRITIONAL-METABOLIC PATTERN

1. History
   a. Typical daily food intake? (Describe.) Supplements (vitamins, type of snacks)?
   b. Typical daily fluid intake? (Describe.)
   c. Weight loss or gain? (Amount) Height loss or gain? (Amount)
   d. Appetite?
   e. Food or eating: Discomfort? Swallowing? Diet restrictions?
   f. Heal well or poorly?
   g. Skin problems: Lesions? Dryness?
   h. Dental problems?

2. Examination
   d. Actual weight, height. e. Temperature.
   f. Intravenous feeding–parenteral feeding (specify)?

ELIMINATION PATTERN

1. History
   b. Urinary elimination pattern? (Describe) Frequency? Problem in control?
   c. Excessive perspiration? Odor problems?
   d. Body cavity drainage, suction, and so on? (Specify.)

2. Examination—when indicated: examine excreta or drainage color and consistency.
ACTIVITY-EXERCISE PATTERN

1. History
   a. Sufficient energy for desired or required activities?
   b. Exercise pattern? Type? Regularity?
   c. Spare-time (leisure) activities? Child: play activities?
   d. Perceived ability (code for level) for:

   Feeding ___________________________ Dressing ___________________________
   Cooking ___________________________
   Bathing ___________________________ Grooming ___________________________
   Shopping ___________________________
   Toileting ___________________________ General mobility _______________________
   Bed mobility ________________________
   Home maintenance _____________________

   Functional Level Codes: Level 0: full self-care
   • Level I: requires use of equipment or device
   • Level II: requires assistance or supervision from another person
   • Level III: requires assistance or supervision from another person and equipment or device
   • Level IV: is dependent and does not participate

2. Examination
   a. Demonstrated ability (code listed above) for:

   Feeding ___________________________ Dressing ___________________________
   Cooking ___________________________
   Bathing ___________________________ Grooming ___________________________
   Shopping ___________________________
   Toileting ___________________________ General mobility _______________________

   b. Gait ___________________________ Posture ___________________________ Absent body part? ____________________
   (Specify)

   c. Range of motion (joints) ___________________ Muscle ___________________ Firmness ___________________
   d. Hand grip ___________________________ Can pick up a pencil? ________________
   e. Pulse (rate) _______________________ (rhythm) ________________________ Breath sounds ________________
   f. Respiration (rate) ________________ (rhythm) ________________________ Breath sounds ________________
   g. Blood pressure ______________________
   h. General appearance (grooming, hygiene, and energy level)

SLEEP-REST PATTERN

1. History
   a. Generally rested and ready for daily activities after sleep?
   b. Sleep onset problems? Aids? Dreams (nightmares)? Early awakening?
   c. Rest-relaxation periods?

2. Examination
   a. When appropriate: Observe sleep pattern.
COGNITIVE-PERCEPTUAL PATTERN

1. History
   a. Hearing difficulty? Hearing aid?
   b. Vision? Wear glasses? Last checked? When last changed?
   c. Any change in memory lately?
   d. Important decision easy or difficult to make?
   e. Easiest way for you to learn things? Any difficulty?
   f. Any discomfort? Pain? When appropriate: How do you manage it?

2. Examination
   a. Orientation.
   b. Hears whisper?
   c. Reads newsprint?
   d. Grasps ideas and questions (abstract, concrete)?
   e. Language spoken.
   f. Vocabulary level. Attention span.
Functional Health Patterns Assessment (Adult) - cont’d

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? Annoyed? Fearful? Anxious?
   e. Ever feel you lose hope?

2. Examination
   a. Eye contact. Attention span (distraction)
   b. Voice and speech pattern. Body posture
   c. Nervous (5) or relaxed (1); rate from 1 to 5.
   d. Assertive (5) or passive (1); rate from 1 to 5.

ROLES-RELATIONSHIPS PATTERN

1. History
   a. Live alone? Family? Family structure (diagram)?
   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. When appropriate: Income sufficient for needs?
   i. Feel part of (or isolated in) neighborhood where living?

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

SEXUALITY-REPRODUCTIVE PATTERN

1. History
   a. When appropriate to age and situations: Sexual relationships satisfying? Changes? Problems?
   b. When appropriate: Use of contraceptives? Problems?

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

COPING-STRESS TOLERANCE PATTERN

1. History
   a. Any big changes in your life in the last year or two? Crisis?
   b. Who’s most helpful in talking things over? Available to you now?
   c. Tense or relaxed most of the time? When tense, what helps?
   d. Use any medicines, drugs, alcohol?
   e. When (if) have big problems (any problems) in your life, how do you handle them?
   f. Most of the time is this (are these) way(s) successful?

2. Examination: None.
VALUES-BELIEFS PATTERN

1. History
   a. Generally get things you want from life? Important plans for the future?
   b. Religion important in life? When appropriate: Does this help when difficulties arise?
   c. When appropriate: Will being here interfere with any religious practices?

2. Examination: None.

3. Other concerns
   a. Any other things we haven’t talked about that you would like to mention?
   b. Any questions?