

Overview of Health Assessment

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Purpose: To gather systematic information that guides clinical decision-making, promotes early detection of problems, and evaluates the effectiveness of interventions.

1. Definition & Scope

Aspect	Description
Health Assessment	A comprehensive, ongoing process of collecting, verifying, and interpreting data about an individual's physical, psychological, social, and spiritual health.
Levels	- Primary (routine check-ups, health promotion) - Secondary (screening for early disease) - Tertiary (monitoring chronic conditions, rehabilitation)
Settings	Hospitals, clinics, community health centers, home visits, telehealth platforms.

2. Core Components (The “SOAP” Framework)

Component	What It Involves	Typical Sources
Subjective Data (S)	Patient's own words: chief complaint, history of present illness, past medical/surgical history, family history, social history, review of systems, functional status, health beliefs.	Interview, questionnaires, patient-generated health data (apps, diaries).
Objective Data (O)	Measurable findings: vital signs, physical exam observations, laboratory results, imaging, diagnostic tests, functional assessments.	Physical exam, labs, imaging reports, device outputs (e.g., glucometer).
Assessment (A)	Clinician's synthesis: differential diagnosis, identification of health problems, prioritization of issues, risk stratification.	Clinical reasoning, evidence-based guidelines.
Plan (P)	Action steps: further testing, treatment, referrals, patient education, follow-up schedule, health-promotion goals.	Treatment protocols, care pathways, patient-centered goals.

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3. The Assessment Process – Step by Step

1. Preparation

- Review prior records, allergies, medications.
- Ensure privacy, cultural sensitivity, and appropriate environment.
- Gather necessary equipment (stethoscope, BP cuff, otoscope, etc.).

2. Data Collection

- **Interview** – open-ended questions & focused history.
- **Physical Examination** – inspection, palpation, percussion, auscultation.
- **Diagnostic Tests** – point-of-care testing, labs, imaging as indicated.

3. Data Verification

- Cross-check patient statements with medical records, medication bottles, family input.
- Use standardized tools (e.g., pain scales, depression inventories).

4. Data Organization

- Document using a structured format (SOAP, PIE, or electronic health record templates).
- Highlight abnormal findings and trends.

5. Analysis & Interpretation

- Apply clinical reasoning models (e.g., hypothetico-deductive, pattern recognition).
- Compare findings to normative data and evidence-based thresholds.

6. Formulation of Assessment

- List problems in order of priority (life-threatening & chronic & preventive).
- Assign diagnosis codes (ICD-10/ICD-11) when appropriate.

7. Planning & Implementation

- Set SMART goals (Specific, Measurable, Achievable, Relevant, Time-bound).
- Choose interventions (pharmacologic, lifestyle, referrals, education).
- Document the plan and obtain patient consent.

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8. Evaluation & Follow-up

- Re-assess at scheduled intervals.
- Adjust plan based on outcomes and patient feedback.

4. Key Assessment Domains

Domain	Core Elements	Common Tools
Physical Health	Vital signs, body systems review, functional mobility	BP