Activities of Daily Living

Resident's Name : _____ Month _____, 20_____

Activity	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Diet:																																
Eaten %	Breakfast:																															
	Lunch:																															
	Dinner:																															
Hydration	At least 6glasses QD																															
Feeding assist:	Yes No																															
Snacks eaten:	10 AM																															
	2 PM																															
	8 PM																															
Fluid intake:																																
Incontinence: Bowel: Yes No Urine: Yes No	BM: S M L																															
Catheter care:	Yes No																															
Briefs/pull ups:	Yes No																															
Bath/shampoo: Partial bath -**PB**	1 Shower 2 bed bath																															
Groom. assist:	Yes No																															
Oral care: Dentures:	qd Yes No																															
Comb hair:	qd																															
Foot care:	qd																															
Nail care: File only	qd PRN																															
Skin Cond: OK Apply lotion. Assist: No assist:	qd Yes No Yes No																															
Glasses:	Yes No																															
Hearing aid:	Yes No																															
Elevate head when in bed:	Yes No N/A																															

Activities of Daily Living

Elevate feet when sitting:	Yes No N/A																														
Assist with dressing:	Yes No																														
Turn in bed or Night check every 2 hrs. or PRN:	PRN Q2hrs N/A																														
Ted hose:	On AM Off PM																														
Linen change:	PRN																														
Laundry:	PRN																														
Exercise:	qd N/A																														
Rec./Activities: Socialize: Prefers privacy: Bed bound:	Yes No Yes No Yes No																														
Activities: Refused (R) Participate (P)																															
Med. Admin.: Self: Assist in med.: Total assist.:	Yes No Yes No Yes No																														
Hospice Other: _____																															
Other according to Service Plan _____ _____																															

Caregiver name:	Initial	Caregiver name:	Initial

Manager: _____ Date: _____