

Activities of *Daily Life*

Activity	Special Instructions	Frequency	Level of Independence
Appointments			
Bathing/Showering			
Child Care			
Cleaning			
Drinking			
Eating			
Errands			
Exercise			
Finances			
Fine Motor Skills			
Getting Dressed			
Grocery Shopping			
Hobbies			
Laundry			
Meal Preparation			
Medication Management			
Mobility/Stairs			
Pet Care			
Phone Calls			
Physical Therapy			
Socialization			
Toileting			
Transportation			

While You Were *Away*

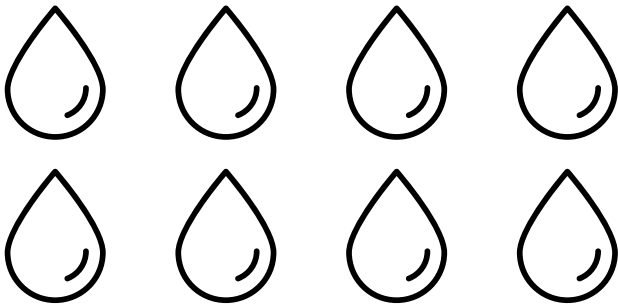
Should you send video or photos throughout the day?

Yes No

Medication:

Morning Night
 Afternoon Additional: _____
 Evening _____

Hydration: *fill in number of cups*



Mood: *circle one*



Housekeeping:

Clean Kitchen Vacuum
 Laundry Additional: _____

Personal Care:

Shower/Bath Change Clothes
 Teeth Additional: _____
 Nails _____

Movement:

Type: _____ Duration: _____

Meals:

Bathroom:

Errands:

NOTES: _____
