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| --- | --- |
| Name: | [Name] |
| Day of the Week | [Day] | Date:  | [Date] |

|  |  |  |
| --- | --- | --- |
| Evaluate / Assets With |  | Notes |
| Nutrition | Breakfast |[ ]   |
|  | A.M Snacks |[ ]   |
|  | Lunch |[ ]   |
|  | P.M Snacks |[ ]   |
|  | Dinner |[ ]   |
|  | Liquid |[ ]   |
|  |
| Hygiene | Shower/Bath |[ ]   |
|  | Brushed Teeth |[ ]   |
|  | Combed Hair |[ ]   |
|  | Clothes Changed |[ ]   |
|  | Other: [Other] |[ ]   |
|  |
| Health | Sleep |[ ]   |
|  | Exercise/Activity |[ ]   |
|  | AM Medications |[ ]   |
|  | PM Medications |[ ]   |
|  | Urine/Bowel Movement |[ ]   |
|  |  |  |  |
| Other / Additional Notes |  |[ ]   |
|  |  |[ ]   |
|  |  |[ ]   |
|  |  |[ ]   |
|  |  |[ ]   |
|  |  |[ ]   |