Visit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Completing Form:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check **YES** for the behaviors that **you have observed** in your **care recipient** in the **past month.**

|  |  |  |
| --- | --- | --- |
| 1. **AGITATION/AGGRESSION**

Does your care recipient get angry or hostile?Resist care from others? |  | 🗖 YES 🗖 NO |
|  |  |  |
| 1. **HALLUCINATIONS**

Does your care recipient see and/or hear things that no one else can see or hear? |  | 🗖 YES 🗖 NO |
|  |  |  |
| 1. **IRRITABILITY/FREQUENTLY CHANGING MOOD**

Does your care recipient act impatient and cranky? Does his or her mood frequently change for no apparent reason? |  | 🗖 YES 🗖 NO |
|  |  |  |
| 1. **SUSPICIOUSNESS/PARANOIA**

Does your care recipient act suspicious without good reason (example: believes that others are stealing from him or her, or planning to harm him or her in some way)? |  | 🗖 YES 🗖 NO |
|  |  |  |
| 1. **INDIFFERENCE/SOCIAL WITHDRAWAL**

Does your care recipient seem less interested in his or her usual activities or in the activities and plans of others? |  | 🗖 YES 🗖 NO |
|  |  |  |
| 1. **SLEEP PROBLEMS**

Does your care recipient have trouble sleeping at night? |  | 🗖 YES 🗖 NO |