

Client's Name: _____

Caregiver's Name: _____

	DATE	DATE	DATE	DATE	DATE	DATE	DATE
	SATURDAY:	SUNDAY	MONDAY:	TUESDAY:	WEDNESDAY:	THURSDAY:	FRIDAY:
Time In:							
Time Out::							
Client's Blood Pressure (Measure and record daily)							
Client's Temperature (Measure and record daily)							
Personal Care							
Medication reminder							
Shower Assistance/Bed Bath							
Mouth care							
Dressing Assistance							
Eating							
Prepare meals/cooking							
Feed Client							
Toileting							
Urinal/Bedpan							
Diaper Change							
Activity							
Assistance with transfer to chair/wheelchair/bed							
Range of Motion Exercises							
Walking/Climbing stairs							
Light Housekeeping							
Making and changing the bed							
Dusting							
Sweeping							
Empty Trash							
Personal laundry							
Wash dishes & cooking utensils							
Shopping for client							

Client's Signature: _____

DATE: _____

Caregiver's Signature: _____

DATE: _____

