

Client Record for _____

te _____ / _____ / _____

Day of the Week _____

Staff Name	Hours

Activity	_____	Initial where appropriate
Signs of Illness	_____	
Description of Clothing	_____	
Breakfast	_____	Bowel Movement
Lunch	_____	Incontinence
Dinner	_____	Exercise
Sleep Pattern	_____	ID / Wallet
_____	_____	Dentures, glasses, etc.
_____	_____	Menstruation
_____	_____	Nail Care
_____	_____	Incident Report
_____	_____	
_____	_____	

Day's Events (Descriptive enough to be able to re-create client's day)

Initial when read