

Cognitive and functional changes observed by the family caregiver

Patient's name : _____

Chart No. : _____

DOB : _____

Identify any **significant changes observed** in your loved one's usual day-to-day functioning. Specify when you noticed this change (e.g. +/- 3 weeks, 6 months, 2 years).

Lifestyle habits	Since when?	Example of change observed
Nutrition/Hydration <input type="checkbox"/> Weight gain or loss <input type="checkbox"/> Changes in eating habits <input type="checkbox"/> Appetite		
Tobacco/Alcohol/Drugs <input type="checkbox"/> Amount consumed <input type="checkbox"/> Frequency		
Sleep <input type="checkbox"/> Insomnia <input type="checkbox"/> Not getting much sleep <input type="checkbox"/> Other		
Activities/Leisure/Pastimes <input type="checkbox"/> Participating in social activities <input type="checkbox"/> Pursuing their favourite leisure activities <input type="checkbox"/> Other		
Functional autonomy	Since when?	Example of change observed
Example of change observed <input type="checkbox"/> Eating <input type="checkbox"/> Preparing meals <input type="checkbox"/> Rotating foods in the refrigerator <input type="checkbox"/> Taking care of their appearance (makeup/beard) <input type="checkbox"/> Choosing clothing appropriate to the situation <input type="checkbox"/> Alternating clothing <input type="checkbox"/> Other		
Incontinence <input type="checkbox"/> Holding their urine and stools <input type="checkbox"/> Using toilets <input type="checkbox"/> Other		
Mobility/Balance/Falls <input type="checkbox"/> Getting around without losing their balance <input type="checkbox"/> Getting around safely <input type="checkbox"/> Other		
Inside and outside maintenance <input type="checkbox"/> Maintaining their home inside/outside <input type="checkbox"/> Doing manual work <input type="checkbox"/> Other		
Going grocery shopping <input type="checkbox"/> Paying or using a bank card <input type="checkbox"/> Purchasing necessary items <input type="checkbox"/> Other		
Taking their medication <input type="checkbox"/> How they take their medications <input type="checkbox"/> Forgetfulness		
Managing their budget <input type="checkbox"/> Understanding their bank statements <input type="checkbox"/> Paying their bills <input type="checkbox"/> Writing cheques <input type="checkbox"/> Other		

Using appliances/devices <input type="checkbox"/> Taking messages <input type="checkbox"/> Using the telephone/internet <input type="checkbox"/> Using household/electric appliances <input type="checkbox"/> Other		
Driving and transportation <input type="checkbox"/> Respecting traffic signs and speeds <input type="checkbox"/> Avoiding accidents <input type="checkbox"/> Driving safely <input type="checkbox"/> Other		
Behaviour/Mood	Since when?	Example of change observed
<input type="checkbox"/> Depressive symptoms <input type="checkbox"/> Anxiety <input type="checkbox"/> Irritability, verbal or physical aggressiveness <input type="checkbox"/> Hallucinations/paranoid thoughts <input type="checkbox"/> Disturbing or inappropriate behaviour <input type="checkbox"/> Wandering/running away <input type="checkbox"/> Passiveness, apathy <input type="checkbox"/> Other		
Cognition	Since when?	Example of change observed
Language <input type="checkbox"/> Searching for their words, using the wrong word <input type="checkbox"/> Following a group conversation <input type="checkbox"/> Understanding what is being said (without impaired hearing) <input type="checkbox"/> Finishing their sentences <input type="checkbox"/> Other		
Orientation <input type="checkbox"/> Recognizing known places and routes <input type="checkbox"/> Remembering the date and the day <input type="checkbox"/> Recognizing familiar people <input type="checkbox"/> Other		
Memory <input type="checkbox"/> Information given/received <input type="checkbox"/> Where objects are located <input type="checkbox"/> Appointments, birthdays, family events <input type="checkbox"/> Other		
Executive functions <input type="checkbox"/> Finishing things they started <input type="checkbox"/> Planning and organizing <input type="checkbox"/> Reacting and making decisions in unusual circumstances <input type="checkbox"/> Other		
Attention/concentration <input type="checkbox"/> Keeping focused on a task <input type="checkbox"/> Doing two things at a time <input type="checkbox"/> Other		

Adapted from Changements cognitifs et fonctionnels observés par le proche aidant [cognitive and functional changes observed by the family caregiver]. Centre intégré universitaire de santé et de services sociaux de l'Estrie – Centre hospitalier universitaire de Sherbrooke. (2015). Boîte à outils [toolbox]: Évaluation, Diagnostic et Prise en charge des troubles cognitifs

1. If you had to be away for two weeks (travel, hospitalization, etc.), would you be concerned about leaving your loved-one alone?

Yes No Why? : _____

2. Driving: Would you let your loved-one drive alone with your young children in the vehicle?

Yes No Why? : _____

3. What do you find the most difficult in the current situation? : _____

Completed by : _____ Relationship: _____ Date : _____