



401 N. MICHIGAN AVE. • SUITE 1920 • CHICAGO ILLINOIS 60611 • 312/266-1486 • FAX 312-464-0218

4845 WEST DEMPSTER • SKOKIE, IL 60077 • 847/679-6065 • FAX 847/679-3183

HOME SERVICES CLIENT PROGRESS NOTES

Client's Name: _____ SOC: _____

Primary concern(s) only (i.e. Safety, Primary Diagnosis, etc.): _____

Mental Status: Alert____ Dementia: Early____ Late____

Combative____ Belligerent____

Vision: Good____ Poor____

Hearing: R____ L____ Poor____ Hearing Aid____

DNR? Y____ N____

S M T W T F S

Enter Actual Dates Worked

PERSONAL CARE

Bathing: Shower____ Sponge____ Shower Chair____
Shampoo Hair____

Transferring: Supervision____ Min____ Max____ 1____
2____ Hoyer Lift____ Slide Board____

(Must have written verification of training)

Dressing Assistance

Med. Reminders: Breakfast____ Lunch____
Dinner____ Bedtime____

Meal Prep____ B____ L____ D____

Special Diet

Toileting: Incontinent____ Change Depends____
Bedtime____ X/Ray____ Urinal____
Bedpan____ Commode____

Catheter (empty only)____ Ostomy Care____

O2 Change Tubing

ACTIVITY

Walks w/o help____ Supervision____ Unsteady
Gait

Uses cane/walker/crutches

Wheelchair

Requires Driver____ Car Available____

HOUSEHOLD DUTIES

Grocery Shopping

Household Cleaning

Laundry

Caregiver Name: _____ Date: _____