

MY DAILY CARE NEEDS

Resident Name:			Date Completed	Completed By
MY THINKING CHALLENGES AND ABILITIES:			MY TRANSFER & MOBILITY:	
HOW I LIKE TO COMMUNICATE:			PERSONAL AIDE DEVICES I NEED:	
MY DRESSING HABITS/MY PERSONAL HYGIENE NEEDS (INCLUDING ORAL HEALTH):			MY DINING/DIET ROUTINE:	

MY DAILY CARE NEEDS continued

Resident Name:

MY BATHROOM ROUTINE:

MY REST & SLEEP ROUTINE:

MY BATHING ROUTINES:

THINGS I LOVE TO DO:

WAYS TO HELP ME AVOID FEELING LONELY:

THINGS THAT I FIND CALMING/THE WAY I LIKE TO BE APPROACHED: