Behavior Assessment Checklist **Note: Document only the presence of behaviors**

BEHAVIORS **Shift:**	noc	am	pm	noc	am	pm	noc	am	pm	noc	am	pm	noc	am	PM	noc	am	pm	noc	am	pm	noc	am	pm	noc	AM	PM	Noc	am	pm	noc	am	pm	noc	am	pm	noc	am	pm	noc	am	pm
Date:																																								
Initials:																																							
**** Chart Nurses Initials q Shift **->**																																							
PSYCHOTIC																																							
Delusion																																							
Disorganized thought process																																							
Hallucination – auditory																																							
Hallucination – tactile																																							
Hallucination – visual																																							
Paranoia																																							
DANGER TO OTHERS																																							
Biting																																							
Hitting																																							
Kicking																																							
Physical resistance																																							
Spitting																																							
Throwing items																																							
DANGER TO SELF																																							
lack of safety awareness																																							
self-biting																																							
self-hitting																																							
DEPRESSIVE SYMPTOMS																																							
anger/swearing																																							
apathy – hopelessness																																							
c/o depression																																							
crying																																							
negative statements																																							
refusing food/meds/care																																							
repetitive statements																																							
repetitive complaints																																							
refusing food																																							
sad expression/sadness																																							
self-deprecation																																							
Sleeplessness																																							
Tearfulness																																							
worthlessness feelings																																							
ANXIETY / DEMENTIA																																							
calling out																																							
Fearful																																							
Isolation																																							
pacing/fidgeting																																							
refusing care (verbal)																																							
Rummaging																																							
swearing/cursing																																							
tearing items																																							
Threatening																																							
Undressing																																							
yelling/screaming																																							
SEXUAL ISSUES																																							
sexual behaviors																																							
CARE ISSUES																																							
pulling off diapers																																							
pulling out tubes / IV's																																							

Initial			
Signature			
Initial			
Signature			

Resident: _____ **Note: Document only the presence of behaviors**