Mood and Behavior Assessment Log

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MOOD AND BEHAVIOR ASSESSMENT LOG

Behavior/Mood Category	Date	Possible Causes *(refer to key)*	Description	Mood/Behavior Documentation	Possible Medical Complication	Initials
PHYSICAL BEHAVIOR SYMPTOM DIRECTED TOWARD OTHERS Hits, kicks, pulls hair, scratches, pinches, bites, spits, pushes, shoves, pushes w/c into objects, sexually abusive, throwing food or others Other: _____						
VERBAL BEHAVIOR SYMPTOM DIRECTED TOWARD OTHERS Threatening, screaming at, or cursing/yelling at others, making disruptive noises Other: _____						
RESISTIVE TO CARES Refuses assist with ADLS, refuses bath, verbal or physical resistance to taking medications, refusing treatments, or eating Other: _____						
EATING DISTURBANCE Refusing meals, playing with food, stealing food, taking food off others plate/tray, throwing food Other: _____						
WANDERING Moving with no rational purpose, seemingly being oblivious to needs or safety Other: _____						
DELUSIONAL A fixed, false misconception or belief not shared by others that the resident holds even in the face of evidence to the contrary Other: _____						
HALLUCINATIONS The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch Other: _____						

Resident Name_____ Medical Record#_____ Case Mix_____

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SOCIALLY INAPPROPRIATE Resident may exhibit disruptive crying, inappropriate laughter, language or gestures that are disruptive, repetitive statements or issues, attention seeking through constant complaints of health, manipulates others, plays one against another, discusses the conditions or behaviors of other residents with others, hoarding, public disrobing Other: _____						
SEXUALLY INAPPROPRIATE Resident exhibits with public touching of genitals, exhibits self sexually in public, inappropriate touching of others, sexual comments, etc. Other: _____						
LOSS OF INTEREST Withdrawal from activities, decline in participation, reduced social interaction, social isolation in room or private area of building Other: _____						
SLEEP-CYCLE ISSUES Awake during the night, unpleasant mood in the morning, insomnia, change in usual sleep pattern Other: _____						
INAPPROPRIATE SELF CARE Hides food, silverware/dishes, removes protective devices (alarms), attempts unsafe self-transfers, resists changing clothing, excessive changing of clothes, layering of clothing affecting dignity, pervasive concern with bowel or bladder, cleans self excessively Other_____						
PROPERTY DESTRUCTION Takes others belongings, throws furniture or objects, throwing items or feces, tears clothing, breaks objects, removes personal items (dentures, hearing aids) and breaks or loses, tampers with equipment Other_____						
SELF INJURIOUS BEHAVIOR Bites, scratches, hits self with objects or hands, puts objects in ear, mouth, nose, eats inedible substances (paper, cigarette butts), previous attempts of suicide/self- harm Other_____						

Resident Name_____ Medical Record#_____ Case Mix_____

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VERBAL EXPRESSIONS OF DISTRESS Makes negative statements, repetitive questions and verbalizations, persistent anger with self or others, self-depreciation, unrealistic fears, recurrent statements that something terrible is about to happen (believes he/she is about to die, repetitive health complaints, repetitive anxious concerns, spiritual distress Other: _____						
SAD, ANXIETY, MOOD Sad, pained or worried facial expressions, crying, tearfulness, repetitive physical movements, fidgeting, picking, pacing, grief, paranoia, hopelessness, loss of self worth, lethargy, irritability, agitated, hand wringing, withdrawal, suicidal ideation Other: _____						
OTHER:						

POSSIBLE CAUSES (KEY)

A. Medication (specify)	**E. Change in Caregiver**	**I. Anger**	**M. Understimulation**	**Q. Medical Conditions (specify)**	**U. Delirium**
B. Light Levels/Glare	**F. Change in Roommate**	**J. Fear**	**N. Overstimulation**	**R. Treatment/Procedures (specify)**	**V. Pain**
C. Temperatures	**G. Mood/Relationship (specify)**	**L. Grief**	**O. Physical Devices**	**S. Mental Illness**	**W. Other**
D. Change in Room	**H. Sensory Impairment**	**K. Noise**	**P. Cognitive Impairment**	**T. Communication Prob. (specify)**	

Quarter 1: Signature_____ Date_____ **Quarter 3: Signature_____ Date_____**

Quarter 3: Signature_____ Date_____ **Quarter 4: Signature_____ Date_____**

Resident Name_____ Medical Record#_____ Case Mix_____