PATHWAY HEALTH
Insight | Expertise | Knowledge

LeadingAge®

MOOD AND BEHAVIOR ASSESSMENT

Behavior/Mood Category	Date	Possible Cause (refer to key)	Description	Mood/Behavior Documentation	Possible Medical Complication	Initials
PHYSICALLY ABUSIVE Hits, kicks, pulls hair, scratches, pinches, bites, spits, pushes, shoves, pushes w/c into objects or others Other: _____						
VERBALLY ABUSIVE Threats, teases or harasses, yells, swears, screams, constant loud singing that is disruptive to others Other: _____						
RESISTIVE TO CARES Refuses assist with ADLS, refuses bath, refusing medications, treatments, or eating Other: _____						
EATING DISTURBANCE Refusing meals, playing with food, stealing food, taking food off others plate/tray Other: _____						
WANDERING Aimless wandering, wanders into private facility areas/other resident rooms Other: _____						
DELUSIONAL A fixed, false 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: _____						
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 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: _____						

Resident Name_____ **Medical Record #**_____ **Case Mix**_____

PATHWAY HEALTH
Insight | Expertise | Knowledge

LeadingAge®

MOOD AND BEHAVIOR ASSESSMENT

Behavior/Mood Category	Date	Possible Cause (refer to key)	Description	Mood/Behavior Documentation	Possible Medical Complication	Initials
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, tears clothing, breaks objects, removes personal items (dentures, hearing aids) and breaks or looses, 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_____**						
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** **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 Condition(specify)	U. Delirium
B. Light Levels/Glare	F. Change in Roommate	J. Fear	N. Overstimulation	R. Treatment/Procedure(specify)	V. Pain
C. Temperatures	G. Mood/Relationship(specify)	K. Noise	O. Physical Devices	S. Mental Illness	W. Other
D. Change in Room	H. Sensory Impairment	L. Grief	P. Cognitive Impairment	T. Communication Problem(specify)	

Quarter 1: Signature_____ Date_____ Quarter 3: Signature_____ Date_____

Quarter 2: Signature_____ Date_____ Quarter 4: Signature_____ Date_____

Resident Name_____ Medical Record #_____ Case Mix_____