

PERIODIC OBSERVATION CHECK SHEET

Patient Name: _____
Date: _____
Time: _____
Observer Name: _____

BEHAVIORAL

*Use the Measurement column to record any measurements you took, such as how many occurrences of an event happened over a given period of time (3 seizures in 8 hours)

Observation	Description	Measurement*
Mood changes		
Harmful behavior to self		
Harmful behavior to others		
Unusual fatigue		
Unusual attachments to people		
Unusually withdrawn		
Seizure		

EXTERNAL

*Use the Measurement column to record any measurements you took, such as how many occurrences of an event happened over a given period of time (weight changed from 154 to 146 between x and y date)

Observation	Description	Measurement*
Skin changes (burns, scratches, rashes, bruises, etc.)		
Blood in stool or on toilet paper		
Blue- or purple-tipped nails, lips, fingers, or toes		
Infection that does not respond to treatment		
Weight gain or loss		
Conditions that decrease mobility (broken bone, strained or sprained muscle or ligament)		
Change in sleep patterns (time to bed, awake during night, up early, increase/decrease in naps)		
Changes in breathing patterns during sleep		
Changes in patterns of elimination (frequency, consistency)		
Menses (irregularity in cycle, amount of bleeding, etc.)		
Diarrhea		
Vomiting		

SUMMARY OBSERVATION CHECK SHEET

Patient Name: _____

Date: _____

BEHAVIORAL

Observation	Date/Time	Measurement	Date/Time	Measurement	Date/Time	Measurement	Date/Time	Measurement	Date/Time	Measurement
Mood changes										
Harmful behavior to self										
Harmful behavior to others										
Unusual fatigue										
Unusual attachments to people										
Unusually withdrawn										
Seizure										

EXTERNAL

Observation	Date/Time	Measurement	Date/Time	Measurement	Date/Time	Measurement	<i>Date/Time</i>	Measurement	<i>Date/Time</i>	Measurement
Skin changes (burns, scratches, rashes, bruises, etc.)										
Blood in stool or on toilet paper										
Blue- or purple-tipped nails, lips, fingers, or toes										
Infection that does not respond to treatment										
Weight gain or loss										
Conditions that decrease mobility (broken bone, strained or sprained muscle or ligament)										
Change in sleep patterns (time to bed, awake during night, up early, increase/decrease in naps)										
Changes in breathing patterns during sleep										
Changes in patterns of elimination (frequency, consistency)										
Menses (irregularity in cycle, amount of bleeding, etc.)										
Diarrhea										
Vomiting										

INTERNAL

Observation	Date/Time	Measurement	Date/Time	Measurement	Date/Time	Measurement	<i>Date/Time</i>	Measurement	<i>Date/Time</i>	Measurement
Increases in sinus and lung congestion										
Increased or decreased blood sugar levels										
Episodes of high or low body temperatures										
Blood pressure										
Heart rate										