

# Tracking the changes

IN YOUR RELATIVE'S OR FRIEND'S

# Alzheimer's symptoms

As a caregiver, you are the person most likely to notice changes in your relative's or friend's Alzheimer's disease symptoms. That's why it's important for you to regularly monitor symptoms and report changes to their healthcare provider—so they can provide an appropriate treatment.

**Use this simple tool to keep track of symptom changes and give it to the healthcare provider during your relative's or friend's next appointment.**

Date completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient name:

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Caregiver name:

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Relationship to patient:

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As Alzheimer's disease progresses, your relative or friend may exhibit changes in thinking, behavior, and ability to do everyday activities. It is important for you to keep track of these changes as you notice them.



## Did anything happen this month that was completely out of the ordinary?



## Memory, language, and thought

Your relative's or friend's ability to remember, think clearly, or communicate may change over time.

Please rate all **changes** that you have noticed **since their last visit**:

	New symptom?		Much better	Better	No change	Worse	Much worse
Memory of recent events	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Judgment/reasoning	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spoken/written communication	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting lost/losing things	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awareness of time and place	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning/organizing	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments about changes in memory, language, and thought:



## Activities of daily living

Your relative or friend may experience worsening in activities of daily living. These are everyday activities that don't usually require assistance.

Please rate all **changes** that you have noticed **since their last visit**:

	New symptom?		Much better	Better	No change	Worse	Much worse
Managing personal finances (paying bills)	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household tasks (laundry, making meals)	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hobbies/interests	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using common household devices (microwave, remote control)	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal care (getting dressed, bathing, grooming, toileting)	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting around outside the home	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating without help	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to spend time alone	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking medicine	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments about changes in activities of daily living:



## Behavior, mood, and personality

Your relative's or friend's behavior and attitude may change over time.

Please rate all **changes** that you have noticed **since their last visit**:

	New symptom?		Much better	Better	No change	Worse	Much worse
Restlessness/anxiety	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability/agitation/aggression/resistance	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in sleep patterns	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing or thinking things that aren't real	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in mood (large increase in sadness or happiness)	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest/withdrawal	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate/unusual behavior	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments about changes in behavior, mood, and personality:

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Thinking about your relative or friend over the past month, please list your **top 3 concerns** that you would like the healthcare provider to be aware of:

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3. 

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Have there been any changes in medicine, hospitalizations, or falls since their last visit?

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**Talk to the healthcare provider today** if your relative's or friend's symptoms are progressing despite their current treatment plan.



## Caregiver stress

As a caregiver, you may begin to notice changes and increased stress in your own life. These changes are important to monitor as well. Some common concerns from caregivers are listed below.

What have you been feeling or experiencing **over the past month?**

	Never	Rarely	Sometimes	Quite frequently	Nearly always
Stress due to work/family responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in personal health/habits (sleeping, eating, exercising)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not enough time for yourself (social or personal time, privacy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Embarrassment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial burden	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of guilt/sadness/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anger/resentment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling overwhelmed/exhausted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional comments:

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