

BEHAV5+

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Please check yes for the behaviors that **you have observed** in your **care recipient** in the **past month**.

1. AGITATION/AGGRESSION Does your care recipient get angry or hostile? Resist care from others?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. HALLUCINATIONS Does your care recipient see and/or hear things that no one else can see or hear?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. IRRITABILITY/ FREQUENTLY CHANGING MOOD Does your care recipient act impatient and cranky? Does his or her mood frequently change for no apparent reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. SUSPICIOUSNESS/PARANOIA Does your care recipient act suspicious without good reason (example: believes that others are stealing from him or her, or planning to harm him or her in some way)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. INDIFFERENCE/SOCIAL WITHDRAWAL Does your care recipient seem less interested in his or her usual activities or in the activities and plans of others?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. SLEEP PROBLEMS Does your care recipient have trouble sleeping at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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ID: _____ Date: _____

SERVICES MINI-SCREEN

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