

Daily Caregiver Checklist

A printable daily care record for elderly adults, families and in-home caregivers

Print one copy per day or save a new digital copy to keep a running care record your whole team can use.

Client Name	Date	Caregiver
_____	_____	_____

Morning Routine

Done	Care task or note
<input type="checkbox"/>	Gentle wake-up, opened blinds and provided orientation (day, date and plan)
<input type="checkbox"/>	Toileting assistance completed
<input type="checkbox"/>	Face and hands washed
<input type="checkbox"/>	Teeth brushed / dentures cleaned
<input type="checkbox"/>	Hair combed / groomed
<input type="checkbox"/>	Shaved, if applicable
<input type="checkbox"/>	Dressed in appropriate clothing
<input type="checkbox"/>	Breakfast served: _____ Amount eaten: _____
<input type="checkbox"/>	Morning fluids: _____ Amount: _____

Medications (Morning)

Done	Care task or note
<input type="checkbox"/>	Medication 1: _____ Time given: _____ Taken: Y / N
<input type="checkbox"/>	Medication 2: _____ Time given: _____ Taken: Y / N

Medications (Morning) Continued on Next Page

<input type="checkbox"/>	Medication 3: _____ Time given: _____ Taken: Y / N
<input type="checkbox"/>	Medication 4: _____ Time given: _____ Taken: Y / N
<input type="checkbox"/>	Notes: _____

Mobility and Activity (Morning)

Done	Care task or note
<input type="checkbox"/>	Transfer assistance provided (bed to chair / other): _____
<input type="checkbox"/>	Morning walk or movement: Duration _____ Notes: _____
<input type="checkbox"/>	Exercise or stretching, if prescribed: _____

Cognitive and Emotional Check-In (Morning)

Done	Care task or note
<input type="checkbox"/>	Orientation activity completed
<input type="checkbox"/>	Mood assessment: Good Neutral Agitated Withdrawn Other: _____
<input type="checkbox"/>	Cognitive engagement activity: _____

Midday

Done	Care task or note
<input type="checkbox"/>	Lunch served: _____ Amount eaten: _____
<input type="checkbox"/>	Midday fluids: _____ Amount: _____
<input type="checkbox"/>	Afternoon activity: _____
<input type="checkbox"/>	Rest period: Yes / No Duration: _____
<input type="checkbox"/>	Appointments or errands: _____

Medications (Midday / Afternoon)

Done	Care task or note
<input type="checkbox"/>	Medication 1: _____ Time given: _____ Taken: Y / N
<input type="checkbox"/>	Medication 2: _____ Time given: _____ Taken: Y / N
<input type="checkbox"/>	Medication 3: _____ Time given: _____ Taken: Y / N
<input type="checkbox"/>	Medication 4: _____ Time given: _____ Taken: Y / N
<input type="checkbox"/>	Notes: _____

Evening Routine

Done	Care task or note
<input type="checkbox"/>	Dinner served: _____ Amount eaten: _____
<input type="checkbox"/>	Evening fluids: _____ Amount: _____
<input type="checkbox"/>	Evening hygiene: washed up / bath or shower / oral care
<input type="checkbox"/>	Changed into nightwear
<input type="checkbox"/>	Bedroom prepared: nightlight on, path to bathroom clear, phone/alert device within reach
<input type="checkbox"/>	Evening check-in completed: mood / concerns noted below

Medications (Evening)

Done	Care task or note
<input type="checkbox"/>	Medication 1: _____ Time given: _____ Taken: Y / N
<input type="checkbox"/>	Medication 2: _____ Time given: _____ Taken: Y / N
<input type="checkbox"/>	Medication 3: _____ Time given: _____ Taken: Y / N
<input type="checkbox"/>	Medication 4: _____ Time given: _____ Taken: Y / N

Medications (Evening) Continued on Next Page

<input type="checkbox"/>	Notes: _____
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Household Tasks Completed

Done	Care task or note
<input type="checkbox"/>	Dishes washed / kitchen wiped down
<input type="checkbox"/>	Pathways cleared
<input type="checkbox"/>	Trash emptied, if applicable
<input type="checkbox"/>	Laundry: Washed Dried Folded Put away
<input type="checkbox"/>	Other: _____

Health Observation Notes

Observation	Notes
Skin condition (redness, bruising, wounds)	_____ _____
Pain or discomfort reported	_____ _____
Elimination: Normal / Constipation / Diarrhea / Incontinence noted	_____ _____
Falls or near-falls	_____ _____
Changes in behavior, cognition, or mood from baseline	_____ _____
Other observations	_____ _____
Total fluids for the day: _____ glasses / cups	_____ _____

Caregiver signature: _____	Time completed: _____
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For non-medical daily care tracking only. This form does not replace professional medical advice or emergency care.

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