GROUP HOME SOLUTIONS
ASSURING COMPLIANCE & QUALITY CARE

ACTIVITIES OF DAILY LIVING (ADL) CHECKLIST

Care Recipient Name: _____ Insurance ID:_____

Caregiver Name: _____

Day/Date	
Time In	
Time Out	
Personal Care:	
Tub Bath/Shower Assistance	
Bed Bath/Sink Bath	
Shampoo Hair	
Shave Client	
Mouth Care	
Dressing Assistance	
Eating:	
Feed Client	
Toileting:	
Urinal/Bedpan	
Transfer to toilet/commode	
Diaper	
Activity:	
Walks without help	
Uses cane/walker/crutch/wheelchair	
Needs hands on help with walking	
Assistance with transfer to chair/wheelchair/bed	

Notes:_____
_____
_____

Caregiver Signature: _____ Date: _____