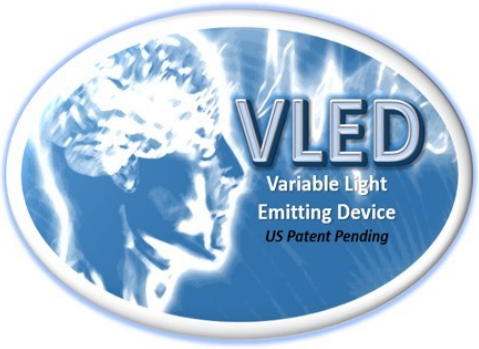

FORM TO BE COMPLETED BY CAREGIVER

(Circle one)

AILMENT: Alzheimer's, Parkinson's, Stroke, Other :

YEARS/MONTHS DIAGNOSED :

NAME:

CAREGIVER NAME:

DATE:

CHECK COLUMN THAT ARE APPLICABLE TO:

Place number between 0—9 with 9 being the most severe in each column .		
Symptom	**AFFECTED PERSON**	**CAREGIVER**
Reduced concentration		
Trouble thinking		
Memory problems		
Anxiety/Nervousness		
Repeated communications		
Irritability/Anger		
Tiredness		
Low Mood/Depression		
Headaches		
Dizziness		
Blurred or double vision		
Sensitivity to bright light		
Violent destructive behavior (self)		
Violent destructive behavior (to others)		
HOURS OF SLEEP LAST NIGHT		
RETURN TO INFO@VLEDUSA.COM WHEN COMPLETED		