

Condensed CAPS Assessment

Part 1: Four-ADLs

Mobility	Ambulation <input type="checkbox"/> Assist needed <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Always/All phases <input type="checkbox"/> History of Falls
	Transfer <input type="checkbox"/> Assist needed <input type="checkbox"/> Inside <input type="checkbox"/> Assist needed at least 4 days/mo <input type="checkbox"/> Always/All phases <input type="checkbox"/> History of Falls
Eating	<input type="checkbox"/> Assist needed <input type="checkbox"/> Always/All phases <input type="checkbox"/> Direct feeding <input type="checkbox"/> Nutritional IV or Feeding Tube
Elimination	Bladder <input type="checkbox"/> Assist needed <input type="checkbox"/> Assist needed at least monthly <input type="checkbox"/> Always/All phases
	Bowel <input type="checkbox"/> Assist needed <input type="checkbox"/> Assist needed at least monthly <input type="checkbox"/> Always/All phases
	Toileting <input type="checkbox"/> Assist needed <input type="checkbox"/> Assist needed at least monthly <input type="checkbox"/> Always/All phases
Cognition - Behavior	Adaptation <input type="checkbox"/> Assist needed <input type="checkbox"/> Constant, daily & on-going assist
	Awareness <input type="checkbox"/> Assist needed <input type="checkbox"/> On-going & daily intervention
	Judgment/Decision-Making <input type="checkbox"/> Assist needed <input type="checkbox"/> At least weekly <input type="checkbox"/> Daily intervention
	Memory <input type="checkbox"/> Assist needed <input type="checkbox"/> Always needs assist
	Orientation <input type="checkbox"/> Assist needed <input type="checkbox"/> Episodic during the week but less than daily <input type="checkbox"/> Always needs assist
Danger to Self or Others <input type="checkbox"/> Assist needed <input type="checkbox"/> At least monthly <input type="checkbox"/> Always needs assist <input type="checkbox"/> Behavior Care Plan	
Demands on Others <input type="checkbox"/> Assist needed <input type="checkbox"/> Constantly intervene <input type="checkbox"/> Modified only with a 24-hour specialized care setting <input type="checkbox"/> Behavior Care Plan	
Wandering <input type="checkbox"/> Assist needed <input type="checkbox"/> Inside	

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Part 3: Client Details

Medications	See PT-09-022 for Medication Documentation Requirements
Diagnoses	
Strengths & Preferences	
Risks	
Goals	
Equipment	
Personal Elements	
Notes	