

SYMTRAK-8 VERSION 1.0 – CAREGIVER REPORT FORM

PLEASE CIRCLE ONLY 1 ANSWER ON EACH ROW

OVER THE PAST **TWO WEEKS**, HOW OFTEN HAS YOUR LOVED ONE HAD **PROBLEMS** WITH:

1.	FEELING TIRED OR HAVING LOW ENERGY	NEVER	SOMETIMES	OFTEN	ALWAYS
2.	TROUBLE FALLING ASLEEP OR TROUBLE STAYING ASLEEP	NEVER	SOMETIMES	OFTEN	ALWAYS
3.	PAIN INTERFERING WITH DAILY ACTIVITIES	NEVER	SOMETIMES	OFTEN	ALWAYS
4.	TROUBLE WITH VISION OR HEARING	NEVER	SOMETIMES	OFTEN	ALWAYS
5.	TROUBLE WALKING OR TROUBLE MOVING AROUND	NEVER	SOMETIMES	OFTEN	ALWAYS
6.	FEELING SAD, DOWN, DEPRESSED, OR HAVING LESS INTEREST IN DOING THINGS	NEVER	SOMETIMES	OFTEN	ALWAYS
7.	FEELING NERVOUS, ANXIOUS, OR WORRYING TOO MUCH	NEVER	SOMETIMES	OFTEN	ALWAYS
8.	TROUBLE CONCENTRATING ON THINGS OR MEMORY LOSS	NEVER	SOMETIMES	OFTEN	ALWAYS



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