



## SOCIAL HISTORY FORM

I.

Name: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Language spoken: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Number of Brothers: \_\_\_\_\_ Sisters: \_\_\_\_\_

Names and Addresses:

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Spouse's Name: \_\_\_\_\_ No. times married: \_\_\_\_\_

Year Married: \_\_\_\_\_ If deceased, when: \_\_\_\_\_

Number of children: \_\_\_\_\_ List name and addresses below:

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Number of grandchildren: \_\_\_\_\_ great-grandchildren: \_\_\_\_\_

Supportive Friend (s): \_\_\_\_\_

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Description of family structure and relationships:

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\_\_\_\_\_  
\_\_\_\_\_

Church: \_\_\_\_\_ Minister's Name: \_\_\_\_\_

What organizations/clubs do you belong to: \_\_\_\_\_  
\_\_\_\_\_

Former Occupation: \_\_\_\_\_ Year retired: \_\_\_\_\_

Level of Education: \_\_\_\_\_

Military Service: \_\_\_\_ Yes \_\_\_\_ No Branch: \_\_\_\_\_

II.

Is resident able to write own letters/sign documents? \_\_\_\_\_

Is resident able to read and understand his/her own mail? \_\_\_\_\_

Resident is:

\_\_\_\_ alert \_\_\_\_ confused \_\_\_\_ oriented \_\_\_\_ cheerful \_\_\_\_ depressed

Resident is:

\_\_\_\_ ambulatory \_\_\_\_ walker \_\_\_\_ wheelchair \_\_\_\_ in bed

Speech is:

\_\_\_\_ good \_\_\_\_ with difficulty \_\_\_\_ slurred

Vision is:

\_\_\_\_ good \_\_\_\_ w/ glasses \_\_\_\_ poor \_\_\_\_ nearly blind \_\_\_\_ blind

Hearing is:

\_\_\_\_ good \_\_\_\_ poor \_\_\_\_ hearing aid

Political interest? \_\_\_\_ Yes \_\_\_\_ No Democrat: \_\_\_\_ Republican: \_\_\_\_

Hobbies/special interest (s) : \_\_\_\_\_

\_\_\_\_\_

What interesting things should we know about the Resident (i.e. describe personality):

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\_\_\_\_\_

\_\_\_\_\_

Previous mental/health retardation service history? \_\_\_\_\_

\_\_\_\_\_

Current behavioral and social functioning including strengths and problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any history of substance abuse? \_\_\_\_\_

III.

Location of resident prior to admission: \_\_\_\_\_

Reason for admission: \_\_\_\_\_

Medical problems, previous hospitalizations, operations, illnesses: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has he/she been in a Skilled Nursing Facility in the past sixty days? \_\_\_\_\_

What condition brought the Resident to Amerisist? \_\_\_\_\_

\_\_\_\_\_

Discharge Plan, if not long term care:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IV.

Advance Directives/living will: \_\_\_\_\_ Yes \_\_\_\_\_ No

Who is designated as P.O.A.? \_\_\_\_\_

Other legal documents: \_\_\_\_\_

Completed by: \_\_\_\_\_

Information received from: \_\_\_\_\_

Relationship: \_\_\_\_\_

Date: \_\_\_\_\_