

Ashtabula County Board of Developmental Disabilities

SOCIAL HISTORY

Consumer Name: _____
Address: _____
Phone #: _____ DOB: _____ Sex: []Male []Female
Religion: _____ Marital Status: []Single []Divorced []Separated []Widowed
Place of Birth: _____
Responsible Personal Designee/Guardian: _____
Address: _____ Phone #: _____
Current Residence: []Family []ICF/MR []Supported Living/Waiver
Consumer Functional Level: []Mild []Moderate []Severe []Profound IQ: _____
Previous Case Management/Community Support Services: []Yes []No
If Yes, Name of Agency & County: _____

PREVIOUS RESIDENTIAL PLACEMENTS

Table with 4 columns: Facility, Address, Dates, Reason. It contains three empty rows for data entry.

FINANCIAL DATA (CURRENT OR PENDING)

Social Security #: _____ Medicare #: _____ Medicaid #: _____
Life Insurance # and Company: _____
Sources of Income (Amount Per Month):
SSI _____ SSA _____ RR _____ VA _____ Other _____
Payee Name: _____ Phone #: _____
Address: _____
Burial Arrangements: _____

DEVELOPMENTAL HISTORY

(Please include pertinent information regarding: pregnancy, birth, age of speech, mobility, illness, behavior problems, family relationships, date & age that disability was determined)

FAMILY HISTORY

Father's Name: _____ **DOB:** _____

Living Deceased Unknown **Social Security #:** _____ **Education:** _____

Address: _____

Occupation: _____ **Employer:** _____

Health Status: _____

Mother's Name: _____ **DOB:** _____

Living Deceased Unknown **Social Security #:** _____ **Education:** _____

Address: _____

Occupation: _____ **Employer:** _____

Health Status: _____

Step-Father's Name: _____ **DOB:** _____

Living Deceased Unknown **Social Security #:** _____ **Education:** _____

Address: _____

Occupation: _____ **Employer:** _____

Health Status: _____

Step-Mother's Name: _____ **DOB:** _____

Living Deceased Unknown **Social Security #:** _____ **Education:** _____

Address: _____

Occupation: _____ **Employer:** _____

Health Status: _____

Siblings:

Name: _____ DOB: _____ Relationship: _____

Address: _____

Living Deceased Unknown

Name: _____ DOB: _____ Relationship: _____

Address: _____

Living Deceased Unknown

Name: _____ DOB: _____ Relationship: _____

Address: _____

Living Deceased Unknown

Name: _____ DOB: _____ Relationship: _____

Address: _____

Living Deceased Unknown

Other:

Name: _____ DOB: _____ Relationship: _____

Address: _____

Living Deceased Unknown

Name: _____ DOB: _____ Relationship: _____

Address: _____

Living Deceased Unknown

MEDICAL HISTORY

Diseases: _____

Immunizations: _____

Seizures: Type: _____ Frequency: _____ Duration: _____

Allergies: _____

Physical Impairments: _____

Special Appliances: _____

Special Diet: _____

HOSPITALIZATIONS/SURGERIES

Hospital: _____ Reason: _____

Dates: _____ Outcome: _____

Hospital: _____ Reason: _____

Dates: _____ Outcome: _____

Hospital: _____ Reason: _____

Dates: _____ Outcome: _____

Hospital: _____ Reason: _____

Dates: _____ Outcome: _____

List Any Other Serious Accidents/Injuries & Dates

Medical Diagnosis: _____

Current Medication: _____

Medical Doctor: _____ Phone #: _____

EDUCATION HISTORY

School: _____ Address: _____

Dates Attended: From: _____ To: _____ Program: _____

School: _____ Address: _____

Dates Attended: From: _____ To: _____ Program: _____

School: _____ Address: _____

Dates Attended: From: _____ To: _____ Program: _____

School: _____ Address: _____

Dates Attended: From: _____ To: _____ Program: _____

VOCATIONAL HISTORY

Employer: _____ Address: _____

From: _____ To: _____ Type of Work: _____

Employer: _____ Address: _____

From: _____ To: _____ Type of Work: _____

Vocational Training Programs: _____

EMOTIONAL HISTORY

General Attitude/Behavior: _____

Specific Emotional Problems: _____

Describe outbursts or tantrums including frequency, intensity and onset: _____

Most Effective Intervention: _____

ADDITIONAL RELEVANT INFORMATION

Family Interest/Involvement (Include Siblings): _____

Likes/Dislikes and Hobbies: _____

Reads Writes Signs Uses Augmentative Communication Device

PROGRAM PLAN

(Key: I=Independent; R=Refuses; P=Physical Assist; S=Requires Supervision; VP=Requires Verbal Prompts)

ADL/PH Skills: _____

Leisure Skills: _____

Community Living Skills: _____

Social Skills: _____

Domestic Skills: _____

Toileting Skills: _____

Eating Skills: _____

AGENCY INVOLVEMENT (CURRENT AND PAST)

Agency: _____ Service Provided: _____ Dates: _____

Agency: _____ Service Provided: _____ Dates: _____

Agency: _____ Service Provided: _____ Dates: _____

Person Completing Form: _____ Date: _____