Social Health History Questionnaire: please complete the attached and submit with completed application

Name: ______________________________ Prefers to be called: ___________________

Spouse/significant other name: ________________________________
Children____ Pet name/type: ______________________

Birth Place: __________________ Highest level of education______ registered to vote? _____________

Place where you've lived longest and think of as home:

____

Length of time lived in Delaware: __________ Religious preference: ______________________________

Military service: branch/time/ service:

____

Occupation history:

____

How do you prefer to spend your day? ____

Are you a morning, afternoon or evening person? ____

Prefers to socialize with others ____ spend time alone ____ some of each ____

Favorite meals: food likes/dislikes:

____

____

Current or past interests/ hobbies sports:

____

____

General Health (Answer Y/N or check)

Orientation: Alert : oriented to ____self ____place ____ time ____ disoriented ___ lethargic ___ cooperative ___

resistant ______ combative ____

Skin: clear/intact _____ bruises/skin tears ___ rashes ____ pressure injuries ____diabetic ulcers _____

venous/arterial ulcers ____ surgical wounds ____ burns ___ other: ______________________

Dental: own teeth ____ dentures (upper / lower) ____ none __ concerns: ______________________

Social Health History Questionnaire: please complete the attached and submit with completed application

Vision: clear ___ poor ____ legally blind ___ glasses ____

Hearing: clear ____ poor____ deaf ___ hearing aids (left / right) ____

Mobility: independent _____ dependent ____ limited assist ____ extensive assist _____

Cane ________ Walker ______ Wheelchair _____ prosthesis ____

<u>Communication</u>

Verbal: clear ___ unclear ___ non-verbal ___

If non-verbal or unclear, how are needs communicated?

____

Specific or unusual words/gestures used:

____

<u>**Sleep:**</u>

Usual awaken time: __________ Bed time: _____________ naps taken: ____________________________

Quality of sleep: sleeps well at night ___ wakeful ___ difficulty falling asleep ___

Light-sleeper ____ tolerates bedrest ___ restless ___

<u>Hygiene</u> (preference): Shower ____ Tub bath ____ Bed bath ____

time preferred: a.m. ______ p.m. _____

Assistance needed for: brushing teeth/dentures _____ shaving ___ washing face/hands ___

Bathing/showering ___ washing/combing hair ___ trimming finger/toe nails ___

Dressing upper body ___ Dressing lower body ____

<u>**Nutrition/hydration:**</u>

Diet: Regular ____ Cardiac ____ Diabetic ___ Other:_________________________

Mechanical Soft _____ Chopped ____ Puree ____ Feeding tube ____ thick liquids____

Eating: Independent ____ Supervision ____ Limited assist ____ Extensive assist/dependent ____

Preferred Meal times: ____

Snack time/frequency/likes/dislikes: ____

Assistance/Adaptive equipment needed:

____

Social Health History Questionnaire: please complete the attached and submit with completed application

Portion sizes: Small _____ Moderate _____ Large _____

Other dietary issues: Swallowing difficulty ___ Drooling ___ Poor appetite ____ over eating ____

Other: ____

If nonverbal, how does veteran communicate needs for hunger/thirst?

____

Continence: Aware of toilet needs: Always ___ Usually ___ Sometimes ___ Never ___

Toilet use: Independent ___ Supervision ___ Limited Assist ___ Extensive assist/dependent ___

Bladder: Continent: Occasionally ____ Frequently ___ Incontinent ___

Bowel: Continent: Occasionally ____ Frequently ___ Incontinent ___

Supplies needed: Urinal ____ Bedside commode ____ Raised toilet seat ____

Ostomy _____ Catheter _____ Briefs/Pull Ups and or Depends ___

Pain Management: Scheduled ____ As needed ____ Non-medication ____

Acceptable level of pain (0-10) __________

Type/location of pain:

____

Effective:

____

Not effective:

____

If nonverbal, how does veteran communicate pain:

____

Falls:

Last fall: date/place: ____

How often falls occur: _________ x per month

Resulting Injury: No injury ___ Injury ______ Major injury _____

Injury type: (Skin tears, abrasions, bruises, sprains) ______ (Fractures, dislocations, subdural hematoma)____

Social Health History Questionnaire: please complete the attached and submit with completed application

Therapy: Currently receiving at__________________________________ PT __ OT ___ ST___

Previous treatment ______________________________________ PT ___ OT ___ ST ___

Previous Mental/behavioral health inpatient treatment: date/place/diagnosis:

____

Current/previous outpatient mental health treatment: date/provide/diagnosis:

____

Substance abuse treatment: date/place____

Legal history: charge ______________________ currently involved in legal system? ______________________

Trauma and/or sexual abuse history: ____

Current behaviors/moods:

Kicking/hitting others ___ Verbal threatening _____ Hitting/scratching self___ others___

Pinch/scratch : self_____ others _____ Yelling/cursing at others _____ Disrobing ____

Pushing/ grabbing ____ False accusations _____ Disruptive sounds _____

Exit seeking ____ Frequent crying ____ Rocking ____ Sexual inappropriateness_____

Throw/smear food/waste ______ Spitting ____ Refuses care ___ Wandering ___ Pacing ____

Eliminate inappropriate places ___ Hallucinations/Delusions ___ Suspicion of others ___

Withdrawal from others ___ Making faces ___ Little interest or pleasure in doing things___

Depressed/hopeless ____ Feeling tired/little energy ___ Feeling bad about self ____

Trouble concentrating ___ Thoughts of harming self or others ___ Memory loss ____

Calming or soothing practices that help: ____