Social History
(For MRRC and Acquired Brain Injury)

Today's Date:___ / ___ / ____
MM DD YYYY

1. Applicant's Personal Information

*Applicant's First Name	Applicant's Middle Name	*Applicant's Last Name
Nick Name	*Birth date	Email Address
Social Security Number	Height	Weight
Is the Applicant Home Bound? Yes ❑ No ❑	Applicant's Primary way of communicating Speak❑ Other:_____	Applicant's Primary Language.
Country the Applicant was born in: USA ❑ Other:_____	Is the Applicant a US Citizen? Yes❑ No ❑	Does the Applicant Understand English? Yes❑ No❑
Ethnicity Hispanic/Latino Yes❑ No ❑	Race American Indian/Alaska Native ❑ Black or African American ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other ❑	

2. Applicant's Physical Address

*Address			
*City	*State	*County	*Zip

3. Applicant's Mailing Address (if different)

*Address			
*City	*State	*County	*Zip

4. Applicant's Telephone Number(s)

Home Telephone	Work Telephone	Mobile/Cell Telephone

5. Applicant's Birth

- What was the Mother's age when the Applicant was born? _____
- How long was the active labor (in hours)? _____
- What was the Applicant's birth weight? _____
- Was the Mother ill during the pregnancy? Yes ❑ No ❑
- Was miscarriage threatened during the pregnancy? Yes ❑ No ❑
- Were any medical procedures performed during the pregnancy? Yes ❑ No ❑
- Was any anesthetic used during the delivery? Yes ❑ No ❑
- Were any postnatal complications encountered? Yes ❑ No ❑
- What kind of delivery occurred (e.g. normal, breach, C-section, etc.)? _____
- General comments: _____
  _____
  _____
- Did the Mother use any drugs during the pregnancy with the applicant? Yes ❑ No ❑
  If so, list them along with the frequency of use:
  _____

6. Applicant's Childhood Milestones

Please identify the ages when the Applicant successfully achieved the following developmental milestones

Age First Sat Up (in months) _____	Age First Toileted (in months) _____	Age First Walked (in months) _____
Age First Talked (in months) _____		

7. Applicant's Education History

- Age Started School: _____
- Highest Grade Completed: _____
- Years Completed: _____
- Is the Applicant leaving the Public School System? Yes ❑ No ❑ If yes, when? _____
- Special School Related Achievements:_____
  _____

List Each School the Applicant Attended (please list the most recent school first).

Name of School	*Type of School (Elem., Jr./ Middle School, High School, College)	School Phone #	Name of School Contact	Date Started	Date Ended	In Special Ed?	Comments
						Y ❑ N ❑	
						Y ❑ N ❑	
						Y ❑ N ❑	
						Y ❑ N ❑	
						Y ❑ N ❑	

8. Applicant's Employment History

Has the Applicant ever received Supported Employment through Vocational Rehab? Y ❑ N ❑
If so, what year did Applicant receive Vocational Rehab services? _____________

(Please list the Applicant's most recent job first)

Employer	Avg. Hours/Wk	Most Recent Hourly Wage	Nature of Work:	Start Date	End Date
			☐ Paid, with benefits ☐ Paid, without benefits ☐ Volunteer/Unpaid		
Job Title/Description:					
Type of Employment (please check one):					
☐	Integrated Employment – Individual (e.g. Applicant holds/held own job in the community)				
☐	Integrated Employment – Work Crew (e.g. Applicant holds/held job in the community as part of a work crew)				
☐	Facility-Based (i.e. participated in a sheltered workshop, work activity, etc.)				
Work Related Issues (i.e. problems with reliability, other employees, employer, etc.):					
Work-related successes, special skills, etc.:					
Level of Satisfaction with Job (please circle): 1-Not Satisfied 2-Fairly Satisfied 3-Satisfied 4-Extremely Satisfied					

Employer	Avg. Hours/Wk	Most Recent Hourly Wage	Nature of Work:	Start Date	End Date
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Job Title/Description:					
Type of Employment (please check one):					
☐	Integrated Employment – Individual (e.g. Applicant holds/held own job in the community)				
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☐	Facility-Based (i.e. participated in a sheltered workshop, work activity, etc.)				
Work Related Issues (i.e. problems with reliability, other employees, employer, etc.):					
Work-related successes, special skills, etc.:					
Level of Satisfaction with Job (please circle): 1-Not Satisfied 2-Fairly Satisfied 3-Satisfied 4-Extremely Satisfied					

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☐	Integrated Employment – Individual (e.g. Applicant holds/held own job in the community)				
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☐	Facility-Based (i.e. participated in a sheltered workshop, work activity, etc.)				
Work Related Issues (i.e. problems with reliability, other employees, employer, etc.):					
Work-related successes, special skills, etc.:					
Level of Satisfaction with Job (please circle): 1-Not Satisfied 2-Fairly Satisfied 3-Satisfied 4-Extremely Satisfied					

9. Applicant's Social Adjustment

- Does the Applicant have friends? Y ❑ N ❑
- What type of person does the Applicant prefer as a friend (e.g. someone who is older, younger, or the same age, etc.)?
  _____
- Does the Applicant take part in social activities? Y ❑ N ❑
- Does the Applicant lead a lonely life? Y ❑ N ❑
- Does the Applicant avoid other people? Y ❑ N ❑
- Does the Applicant pursue the opposite sex? Y ❑ N ❑
- Additional Comments: _____
  _____

10. Applicant's Problems (List any major health, psychological, physical, other related problems, and diagnoses that currently affect the Applicant's life. If the applicant has a brain injury, please indicate whether the problem occurred before or after the brain injury.)

*Problem Area	*Problem Description	Who observed/ Documented the Problem? (e.g. Mom, Dad, Doctor, Teacher, Sister, Brother, etc.)	Date the Problem Was Resolved

11. Brain Injury

If the applicant has a brain injury, please answer the following:

When (what date) did the brain injury occur? (Please try to be as precise as possible)
Describe the nature of the brain injury.

12. Applicant's Use Of Prostheses/Specialized Equipment

Does the Applicant currently use a prosthesis or any specialized equipment? If so, list each item and whether it is used or not.

*Prosthesis/Specialized Equipment	Description	*Currently Uses?
		Currently Uses ❑ Has, but doesn't use ❑
		Currently Uses ❑ Has, but doesn't use ❑
		Currently Uses ❑ Has, but doesn't use ❑

13. Applicant's Medications (please list all of the medications the Applicant is currently taking)

*Medication Name	*Reason for Taking The Medication	Prescribed By	Date Started Taking the Med	Date Stopped Taking the Med

14. Applicant's Utilization of Medication

- What is done to help/remind the Applicant to take their medication?_____

_____

15. Substance Use

Does the Applicant currently use any substances (e.g. Alcohol, tobacco, etc.)? If so, enter the following:

Type of Substance	Frequency (Daily, Weekly, Monthly)	Comments

16. Applicant's Health Treatments (List any recent visits the Applicant made to see a medical professional – including medical check-ups, outpatient treatments, dental exams, hospital stays, etc.)

*Type of Medical Visit (e.g. Dental, Neurological, Pediatrics, Speech Therapy, Mental Health)	Name of Medical Professional	Treated By What Kind of Medical Professional?	Name of Facility	Type of Treatment	Treatment Start Date or Date of Visit	Discharge/ Recovery Date	Comments
				☐ Inpatient ☐ Inpatient w/ Meds ☐ Meds only ☐ Outpatient ☐ Outpatient w/ Meds			
				☐ Inpatient ☐ Inpatient w/ Meds ☐ Meds only ☐ Outpatient ☐ Outpatient w/ Meds			
				☐ Inpatient ☐ Inpatient w/ Meds ☐ Meds only ☐ Outpatient ☐ Outpatient w/ Meds			
				☐ Inpatient ☐ Inpatient w/ Meds ☐ Meds only ☐ Outpatient ☐ Outpatient w/ Meds			

17. Applicant's Stay In A Nursing Facility (NF) / Intermediate Care Facility for the Mentally Retarded (ICFMR)

*Is the Applicant now, or have they ever been, a resident of a ❑ nursing home or an ❑ ICFMR?

If so, please enter the following:

- Admission Date _____
- Name of the facility _____
- Discharge Date _____

18. Applicant's Allergies

Please list all of the Applicant's Allergies

Type of Allergy	Comments

19. Applicant's Immunizations

Fill in the Immunizations the Applicant has received.

Name of Immunization	Date Received	Who gave the Immunization?

20. Applicant's Appetite

Is the Applicant's current appetite: Good ❑ Fair ❑ Poor ❑

21. Applicant's Family Relationships

Father

*Name	Birth Date	Employed? Y ❑ N ❑ Occupation:_____
Deceased? Y ❑ N ❑ Date: _____ Cause: _____	Adopted the Applicant? Y ❑ N ❑	Telephone Number
Ethnicity/Race	Provides Natural Supports? Y ❑ N ❑	Describe his relationship with the Applicant: (e.g. good, positive, confrontational, etc.)
Does he speak English? Y ❑ N ❑ If not, what language? _____	Lives with the Applicant? Y ❑ N ❑	
Street Address (if not living with the Applicant):		

Mother

*Name	Birth Date	Employed? Y ❑ N ❑ Occupation:_____
Deceased? Y ❑ N ❑ Date: _____ Cause: _____	Adopted the Applicant? Y ❑ N ❑	Telephone Number
Ethnicity/Race	Provides Natural Supports? Y ❑ N ❑	Describe her relationship with the Applicant: (e.g. good, positive, confrontational, etc.)
Does she speak English? Y ❑ N ❑ If not, what language? _____	Lives with the Applicant? Y ❑ N ❑	
Street Address (if not living with the Applicant):		

Stepfather (if applicable)

*Name	Gender	Birth Date	Lives with Applicant?	Provides Natural Supports?	Adopted the Applicant?	Describe his relationship with Applicant (e.g. good, positive, confrontational, etc.)
			Y ❑ N ❑	Y ❑ N ❑	Y ❑ N ❑	
Street Address & Telephone # (if not living with the Applicant):						

Stepmother (if applicable)

*Name	Gender	Birth Date	Lives with Applicant?	Provides Natural Supports?	Adopted the Applicant?	Describe his relationship with Applicant (e.g. good, positive, confrontational, etc.)
			Y ❑ N ❑	Y ❑ N ❑	Y ❑ N ❑	
Street Address & Telephone # (if not living with the Applicant):						

Guardian (Does the Applicant have a court appointed Legal Guardian? If so, fill in the data below.)

*Name	Gender	Birth Date	Lives with Applicant?	Provides Natural Supports?	Describe relationship with Applicant (e.g. good, positive, confrontational, etc.)
			Y ❑ N ❑	Y ❑ N ❑	
*Street Address & Telephone # (if not living with the Applicant):					

Spouse (if the Applicant is/was married)

*Name	Gender	Birth Date	Lives with Applicant?	Marital Status (i.e. Married, Separated, or Divorced)	Provides Natural Supports?	Describe relationship with Applicant (e.g. good, positive, confrontational, etc.)
			Y ❑ N ❑		Y ❑ N ❑	
Street Address & Telephone # (if not living with the Applicant):						

Siblings

*Name	Gender	Birth Date	Lives with Applicant?	Provides Natural Supports?	Address/Telephone (if not living with the Applicant)	Describe relationship with Applicant (e.g. good, positive, confrontational, etc.)
			Y ❑ N ❑	Y ❑ N ❑		
			Y ❑ N ❑	Y ❑ N ❑		
			Y ❑ N ❑	Y ❑ N ❑		
			Y ❑ N ❑	Y ❑ N ❑		
			Y ❑ N ❑	Y ❑ N ❑		
			Y ❑ N ❑	Y ❑ N ❑		

22. Applicant's Other Personal Relationships [e.g. extended family, friends, etc.] (The people entered in this area are considered to be important to the applicant and contribute in some meaningful way to their daily living experiences)

Person's Name	*What is the Relationship?	Lives with Applicant?	Provides Natural Supports?	Address/Telephone (if not living with the Applicant)	Describe relationship with Applicant (e.g. good, positive, confrontational, etc.)
		Y ❑ N ❑	Y ❑ N ❑		
		Y ❑ N ❑	Y ❑ N ❑		
		Y ❑ N ❑	Y ❑ N ❑		
		Y ❑ N ❑	Y ❑ N ❑		
		Y ❑ N ❑	Y ❑ N ❑		
		Y ❑ N ❑	Y ❑ N ❑		

23. Applicant's Professional Relationships (e.g. Doctor, Dentist, School Teacher, etc.)

Professional's Name	*Type of Professional	Date Professional Was Last Seen	Professional's Telephone #	Professional's Address

24. Family Tragedies

Has the Applicant's immediate family encountered any tragedies (e.g. automobile accidents, deaths, major illnesses, etc.)? If so, list and describe them below:

What was the Incident?	Incident Date	Describe the Incident

25. Family Medical History

Does the Applicant have any family members who have notable medical issues or disabilities? If so, identify and describe the issues and/or disabilities.

Describe the Medical Issues/Disabilities

26. Agencies

Is the Applicant currently involved with any city, county, state or federal agencies? If so, enter the following:

*Name of the Agency	Agency Telephone Number	Date the Involvement Started	Agency Contact Person	Case #	Comments

27. Court Orders

Is the Applicant currently affected by any court orders that impact their relationship with DSPD? If so, enter the following:

What Kind of Order is it?	Date of the Order	Comments

28. Applicant's Income

If the Applicant has an income, enter the following information:

Type of Income (e.g. earned, retirement, Social Security, etc.)	Amount	With What Frequency is the Income Received? (e.g. weekly, monthly, annually, etc.)	Is the Income Stable?
			Y ❑ N ❑
			Y ❑ N ❑
			Y ❑ N ❑

29. Assistance

Does the Applicant receive assistance from any private or government agencies? If so, enter the following information.

Type of Assistance (e.g. Food Stamps, Housing, SIC, Unemployment, Charity, etc.)	Describe the Assistance	Amount	With What Frequency is the Assistance Received? (e.g. weekly, monthly, one-time, etc.)

30. Insurance

If the Applicant receives insurance benefits either by himself/herself or through their family, enter the following:

Is the Insurance Primary?	Who Owns the Insurance?	What Type of Insurance is it (e.g.. Private, Medicaid, Medicare, etc.)?	Insurance #	Insurance Start Date

Form Completed By:_____ Date:_____

Intake Worker/Support Coordinator Signature:_____ Date:_____

QMRP/ABISC Signature (if applicable): _____ Date:_____