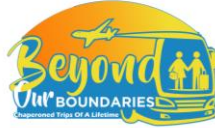


Today's Date: _____



601 Cleveland Ave NW, Suite D
Canton, Ohio 44702
330-455-8111

UI should be faxed to:

Fax Number: _____

Social History Form

Participant:

Legal Name (as it appears on your State ID): _____

Preferred Name (if different from legal name): _____

Home Address: _____ City: _____

State: _____ County: _____ Zip: _____ Phone: () _____

Provider Address (if different from home address): _____

City: _____ State: _____ County: _____ Zip: _____ Phone: () _____

Where do you prefer we send trip info (please check one)? Home Provider

Type of living situation (check):

Family

Apartment (specify type)

Group Home

Independent Living

Age: _____ Birthdate: ____/____/____ Gender: _____

Height: _____ Weight: _____ Marital Status: _____

Eye Color: _____ Hair Color: _____ Race: _____

Any distinguishing features: _____

Contacts, Glasses, Hearing Aids, Other Adaptive Equipment: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Is Participant fully ambulatory? Yes No

Does applicant walk at slow pace or unsteady gait? Yes No

Indicate mobility assistance needed: _____

Is participant able to swim? Yes No

Please specify any water related issues here: _____



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Is participant visually impaired? Yes No

If yes please describe: _____

Is participant hearing impaired? Yes No

Describe any sign language used? _____

Is participant understandable when speaking? Yes No

If not, explain communication system: _____

How does individual make needs known? _____

Medical:

Date of Last Flu Shot: _____

Date of Last Pneumonia Shot: _____

Allergies? Yes No If yes, is an Epi-Pen prescribed? Yes No

If yes please specify (include insect bites, food, etc. and reaction):

Special Diet? Yes No

Describe: _____

Dietary Restrictions? Yes No

Describe: _____

Individual is at risk for aspirating? Yes No

Activity Restrictions? Yes No

Describe: _____

Bowel or Incontinence issues? Yes No

Explain: _____

Medications prescribed for constipation: _____

Medications prescribed for diarrhea: _____



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Diabetic? Yes No

Blood sugar testing? Please list times of day: _____

Independent testing blood sugar? Yes Needs assistance

Parameters for blood sugar: _____

Seizure disorder? Yes No

Describe a typical seizure: _____

Date of most recent seizure: _____

Order for Diastat? Yes No

Individual has a Vagus Nerve Stimulator? Yes No

Physician's order for seizure parameter/protocol: _____

Metal implants such as hip/knee replacements or pace makers? Yes No

Describe type and location: _____

MEDICATIONS

Medications:

Self- Administering WITHOUT assistance

Self- Administering WITH assistance (please identify what assistance is needed):

Individual requires Staff to administer medications

✓ Please provide a current Self-Medication Assessment



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Current List of Medications

Please include prescription medications, over the counter medications, and PRN (as needed) medications.

Med Name ----- Dose ----- Route ----- Time ----- Special Directions

- ✓ _____
- ✓ _____
- ✓ _____

Med Name ----- Dose ----- Route ----- Time ----- Special Directions

- ✓ _____
- ✓ _____
- ✓ _____
- ✓ _____

PRN (as needed) Medications

Med Name ----- Dose ----- Route ----- Time ----- Special Directions

- ✓ _____
- ✓ _____
- ✓ _____
- ✓ _____

A copy of the current medication administration record (MAR) MUST be submitted to Beyond Our Boundaries prior to leaving on a trip.

Packaging Medications

All staff-administered medications must be packaged by the pharmacy in single dose, labeled packaging such as PillPack, Doc-U-Dose or your pharmacy's equivalent. These must be dropped off at our office the day before departure (on Friday for Sunday or Monday departure).

Please note or attach any other relevant medical information about the participant.



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Emergency Info

Legal Guardian: _____ Phone: () _____

Relationship to Participant: _____

Contact 1: _____ Phone: () _____

Relationship to Participant: _____

Contact 2: _____ Phone: () _____

Relationship to Participant: _____

SSA: _____ Phone: () _____

(This is the person from the county board of DD who coordinates all of your services)

Payee: _____ Phone: () _____

Primary Care Physician: _____

Phone: () _____

Preferred Hospital: _____ Phone: () _____

Dentist: _____ Phone: () _____

Other Medical Professionals:

Name: _____ Phone: _____

Specialty: _____

Name: _____ Phone: _____

Specialty: _____

Pharmacy used: _____

Phone: () _____

***BEYOND OUR BOUNDARIES MUST BE NOTIFIED OF ANY CHANGES IN
GUARDIANSHIP***



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Social/Behavioral (if not marked yes please explain)

Does participant interact appropriately with: Staff Yes No
Explain: _____

Does participant interact appropriately with: Peers Yes No
Explain: _____

Does participant interact appropriately with: Strangers Yes No
Explain: _____

Is he/she capable of safely and respectfully sharing a hotel room with another participant? Yes No If no, please explain:

Does he/she understand how to stay with their chaperone and a group?
Yes No If no, please explain:

Does participant smoke? Yes No

Check those that apply and explain below if necessary:

- | | |
|---|---|
| <input type="checkbox"/> Talkative | <input type="checkbox"/> Needs coaxing to join activities |
| <input type="checkbox"/> Has history of stealing/ may steal | <input type="checkbox"/> Talks to strangers |
| <input type="checkbox"/> Fabricates stories | <input type="checkbox"/> Wanders (explain) |
| <input type="checkbox"/> Shy/ withdraw/ keeps to self | <input type="checkbox"/> Teases others |
| <input type="checkbox"/> Is cooperative | <input type="checkbox"/> Helpful/kind to others |
| <input type="checkbox"/> Follows directions | <input type="checkbox"/> Enjoys socialization |
| <input type="checkbox"/> Makes choices | |

Please explain or add any behaviors not covered. *If participant is on a behavior plan please attach:* _____



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Activities of Daily Living: Please check and provide details as needed

Self-Care Skills	Totally Independent	Needs Assistance	Poor	Specify Support Required
Dressing	_____	_____	_____	_____
Bathing	_____	_____	_____	_____
Toileting	_____	_____	_____	_____
Hygiene	_____	_____	_____	_____
Feeding	_____	_____	_____	_____
Skills				
Money	_____	_____	_____	_____
Reading	_____	_____	_____	_____
Writing	_____	_____	_____	_____
Telling time	_____	_____	_____	_____

Please provide any further information if participant is not totally independent that will assist us in making sure that we provide the services that your participant needs.

BEYOND OUR BOUNDARIES MUST BE NOTIFIED OF ANY SIGNIFICANT CHANGES IN ABILITIES AND/OR CARE NEEDS OF THE PARTICIPANT

Name of Person Filling this out: _____

Relation to Participant: _____ Phone: () _____