Today's Date: _____

UI should be faxed to:
_____
Fax Number: _____

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

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:_____

_____

Continued→ 1

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

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: _____

_____

Continued→ 2

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

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

Continued→ 3

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

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.

Continued→ 4

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

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

Continued→

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

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:

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

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

Continued→ 6

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

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 <u>totally independent</u> 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: ( ) _____