LIFE HISTORY TOOL - PSYCHOSOCIAL

For Office Use:

Move-In Date _____

Date LH Tool Completed _____ Level of Living _____ Rm # _____

For Discharge only: Date of Discharge _____

Discharged to _____

GENERAL INFORMATION

Full Name:	Preferred Name: Birthdate:
COMING FROM (place where presently live and LENGTH OF TIME THERE):	Residential History:

Advanced Directive:	☐ Yes	☐ No	On File: ☐ Yes	☐ No
Living Will:	☐ Yes	☐ No	On File: ☐ Yes	☐ No
Do not resuscitate:	☐ Yes	☐ No	On File: ☐ Yes	☐ No
Organ donation:	☐ Yes	☐ No	On File: ☐ Yes	☐ No

Social Security # :	Medicare #:
Secondary Insurance:	ID #
Secondary Insurance claim address:	Secondary Insurance telephone #:
Funeral Home Name, Address, Phone #:	Arrangements made: ☐ Yes ☐ No
Family Contacts:	Address / phone number
Primary Doctor:	Phone No.:
Hospital preference:	
Dentist:	Phone No.:
Ophthalmologist:	Phone No.:
Podiatrist	Phone No.:
Psychiatrist	Phone No.:
Pharmacy	Phone No.:
Other	Phone No.:

LIFE HISTORY TOOL – PSYCHOSOCIAL Name: _____

Please check yes or no if you have a history of the following conditions/symptoms and comment on any additional information that would be important for us to know to help better care for you.

MEDICAL HISTORY

Neurological			
Headaches/pain			Ever had a CVA? ☐ No ☐ Yes, when _____ How has it affected you?
Seizure disorder			
Speech/language			
Sleep difficulties			Do you take any sleeping medication to help you sleep: ☐ No ☐ Yes
Problems with memories of long ago			Explain any sleeping difficulties
Problems with memories of recent events			Is there a diagnosis of dementia? ☐ No ☐ Yes, type _____
Balance/falls			Cognitive Assessment Score: _____ Type of Test _____
Failure to recognize objects			Date of testing: _____
Organization ability			

Psychological			
Anxiety			
Depression			How long have you been depressed:
Lack of energy/fatigue			Were you diagnosed with depression? ☐ No ☐ Yes, when _____
Insomnia			Medication for depression? ☐ No ☐ Yes, what _____
Sleeping a lot			:
Lost interest in usual pleasures			
Over/under eating			
Feeling angry/irritable			
Crying spells			
History of ECT			
Fearful			What are you fearful of:
Dependent on others to make decisions			Who do you depend on to make decisions:
Difficulty concentrating			
Significant losses			
Are you grieving			
Victim of physical abuse			
Victim of sexual abuse			
Victim of emotional abuse			
Significant changes in your life			What recent changes have occurred in your life:
History of behavioral symptoms			Explain the behavioral symptoms (hitting, kicking, biting, sexual etc.:

History of suicide attempts			Explain any suicide attempts and when they occurred: Explain:
History of alcohol/drug abuse			
Do you smoke			

Statement of general feelings:

PSYCHOSOCIAL HISTORY

FAMILY HISTORY

EARLY LIFE:

Birth place:

Grew up:

Family names: Mother: Father:

Sister(s):

Brother(s):

Other significant members:

Relationship with family members while growing up:

Family vacations and recreational activities:

Family anecdotes or interesting stories:

Any significant changes in the family (siblings, parents, grandparents, etc.) relationship from childhood:

LATER LIFE:

Marital status: ☐ Never married ☐ Married/Date of marriage: Spouse's name:

☐ Widowed Death of spouse date: ☐ Divorced

☐ Remarried Date of marriage: Spouse's name:

Relationship with spouse:

Parental status: ☐ Children Names:

Relationship with children while they were growing up and as adults:

Grand and Great-grandchildren:

Other significant people:

EDUCATIONAL / OCCUPATIONAL / MILITARY HISTORY

Educational events: Highest level achieved: Where:

Awards:

Extracurricular activities:

Occupation:

Employed where:

Retired when: After retirement employment:
When did that stop:
Military experience: Veteran: Branch of service:
Stationed where:
War memories / honors:
OTHER SIGNIFICANT LIFETIME HISTORY
Involvement in clubs and community organizations:
Interest in literature or reading:
Interest in music:
Recreational activities (including travel) and hobbies:
Animals or pets:
Politics:
Exercise/Fitness:
Church membership: Clergy Name and Phone #:
Religious / Spiritual Practices:
Holiday and special date traditions:
Other interests:

LIFE TIME INTERESTS

Did you participate in any of the following in THE PAST:

- ☐ Cards or other table games
- ☐ Arts and crafts
- ☐ Exercise/sports
- ☐ Music – what kind
- ☐ Reading/writing
- ☐ Spiritual/religious
- ☐ Other:
- ☐ Trips/shopping
- ☐ Walking/wheeling outdoors
- ☐ Watching TV
- ☐ Gardening or plants
- ☐ Talking or conversing
- ☐ Helping others

In the PAST 6 MONTHS have you been able to:

- ☐ Follow simple directions (3 step)
- ☐ Feel comfortable in a large (more than 10) group
- ☐ Participate in conversations
- ☐ Lead discussion group
- ☐ Prefer independent leisure pursuits such as:
- ☐ Other comments:
- ☐ Follow detailed directives (more than 3 steps)
- ☐ Small group (less than 10)
- ☐ Participate in discussions while in group
- ☐ Prefer to stay in own room

IN THE LAST SIX (6) MONTHS:

While residing in previous residence, describe the daily routine:

Has there been a change in your participation in daily routine? If yes, describe:

IN THE PAST FIVE (5) YEARS:

What significant life experiences have stopped (cessation of driving, inability to participate in favorite social/physical events):

Completed by,
Signature:_____ Date:_____

Informant: ☐ Resident ☐ Family Member/Significant other:_____

☐ Friend _____ ☐ Unable to obtain – reason:_____