Social and Personal History Portfolio

Life Story

Resident Name:	Resident Picutre
Room #:	
Date Completed:	

General Information

Full Name				
Preferred Name:		**Other names or nicknames:**		
Birthdate:		**Birthplace:**		Age:
Gender:	Male Female	**Race:**	Black Hispanic Caucasian Other _____	
Primary Language:	English Other		**Ethnic Background:**	

Who is the person primarily responsible for the resident?		Is primary caregiver currently employed?	FT PT Does not work Work pattern _____
Family support system (List all family members involved in care and care decisions)	Name		Relationship
Who will be responsible for the financial care?	Name		Contact Number and E-mail

Does primary caregiver attend a support group?	Y N Would like to	Where _____ When _____ Resource given _____
Does any other family member have Alzheimer's disease or dementia?	Name	Relationship

Family

Mother		Living Deceased Date: _____	Residence: State: Local: Y N
Father		Living Deceased Date: _____	Residence: State: Local: Y N
Sibling		Living Deceased Date: _____	Residence: State: Local: Y N
Sibling		Living Deceased Date: _____	Residence: State: Local: Y N
Sibling		Living Deceased Date: _____	Residence: State: Local: Y N
Sibling		Living Deceased Date: _____	Residence: State: Local: Y N
Resident Information		Never Married Married Widowed Separated Divorced	Birthdate: _____ Anniversary: _____
Spouse		Nicknames / Pet Names	Relationship Issues / Family Information
Spouse Continued		Living Deceased Date: _____	Relationship Issues / Family Information
Child		Living Deceased Date: _____	Relationship Issues / Family Information
Child		Living Deceased Date: _____	Relationship Issues / Family Information
Child		Living Deceased Date: _____	Relationship Issues / Family Information
Child		Living Deceased Date: _____	Relationship Issues / Family Information

Family continued

Grandchild		Living Deceased Date: _____	Relationship Issues / Family Information
Grandchild		Living Deceased Date: _____	Relationship Issues / Family Information
Grandchild		Living Deceased Date: _____	Relationship Issues / Family Information
Grandchild		Living Deceased Date: _____	Relationship Issues / Family Information
Grandchild		Living Deceased Date: _____	Relationship Issues / Family Information

Education / Occupation

Last Grade / Degree Completed			
Please complete: **Grade School** **High School** **College** **Graduate School**	Location	Experience (pleasant / unpleasant / don't know):	
First Occupation	Location	Name of Company	
Job description or duties performed		Experience (pleasant / unpleasant / don't know):	
Last Occupation	Location	Name of Company	
Job description or duties performed		Experience (pleasant / unpleasant / don't know):	
Veteran	Y N Date: _____	Serve wartime: Y N Which war? _____ Where served?	Branch of Service:

Please share any specific experiences, which were important to your loved one:

Skills and Preferences

Writes	Y N Right Handed Left Handed	**Reads:**	Y N
Religion	Church Involvement: Name of Church: Pastor / Priest: Phone:	Importance of spiritual beliefs:	
Celebration of Holidays	Y N	Check all that apply: Thanksgiving Christmas Easter Passover Hanukkah Rosh Hashanah	
Favorite Things:	Foods: _____ Colors: _____ Season: _____ Songs: _____ TV Shows: _____ Vacation Spot: _____ Celebrity: _____ Movie: _____		
Dislikes / "Pet Peeves"			

Skills and Preferences continued

Personality	Before onset of illness:	Current:
Pattern of relating to others;	Ongoing Involved Social Loner	
Community / Volunteer Involvement	Y N Names of Groups:	

Nutritional Skills and Preferences

Swallowing Problems	Y N	**Pockets Food?**	Y N
Dentures	None Removable Bridge Upper _____ Full _____ Partial _____Lower _____Full _____ Partial		
Use of Utensils	____Fork ____Knife ____Spoon	**Appetite**	___ Good ___Poor ___Eats too fast
Food Preferences			
Drink Preferences			
Food or Drink Dislikes			

Hobbies and Interests

	Past	Present
Listening to music	Y N What kind?	Y N What kind?
Singing/Play Instrument	Y N Instrument What type of music?	Y N Instrument What type of music?
Animals, Pets	Type Name Dislikes	Type Name Dislikes
Children	Enjoys children Does not enjoy children	Enjoys children Does not enjoy children
Sports	Playing Watching	Playing Watching
Games		
Exercising	Y N Type	Y N Type
Dancing	Y N Type	Y N Type
Knitting, needlework, sewing		
Cooking / Baking	Y N Favorite recipes	Y N Favorite recipes
Drawing, painting, art work	Y N Medium	Y N Medium
Gardening	Y N Favorite plants	Y N Favorite plants
Walks	Y N Favorite Time Duration	Y N Favorite Time Duration
Reading	Books Magazine Type	Books Magazine Type
Travels		
Hobbies		
Other		

Cognitive Status and Skills

Physician Diagnosis	Y N Alzheimer's Disease Multi-infarct or stroke related dementia Other: _____
Check all that apply:	
	Difficulty communicating wants and needs
	Difficulty completing sentences
	Sentences do not make sense
	Difficulty naming people
	Apraxia-inability to perform movement
	Aphasia-inability to communicate verbally
	Agnosia- inability to recognize
	Substitutes words that sound like other words
	Has trouble remembering recent events
	Unaware of day and time
	Unable to recognize familiar people
	Unable to recognize familiar places
	Has difficulty concentrating on task or activity
	Takes little or no interest in activities and will not start them by self
	Often asks the same questions over and over again
	Loses or misplaces things
	Hoards objects
	Has difficulty following simple directions
	Wanders from home
	Cannot be left alone; must be supervised at all times
	Wakes you up at night
	Demands constant attention and will not let you out of sight
	Becomes verbally abusive When?
	Becomes combative When?
	Becomes anxious When?
	Becomes agitated When?

Cognitive Status and Skills continued

	Becomes stubborn or uncooperative When?
	Engages in embarrassing or socially inappropriate behavior How?
	Denies or seems unaware that anything is wrong
	Reports seeing or hearing things that are not there
	Frequently appears depressed or withdrawn
	Engages in behavior that is potentially dangerous to self or others When?
Other behaviors that may be a significant problem	
Successful techniques utilized at home	

What event, objects, or activities tend to upset the resident?

Activities of Daily Living Preferences

Describe bedtime routine	Lighting Attire Music TV Blankets Other
Describe mealtime routine and habits	
Describe specific grooming habits (type of razor, make-up)	
Describe bathing preferences and routine	Bath Shower Sponge bath Time of day: Frequency