SOCIAL HISTORY

Name: ______________________________ DOB ___________

Please complete the following questions by check the most accurate answer or filling in the blank:

Are you: □Single □Married □Widowed

Are you : □Employed □Unemployed □ Retired □Student
If employed or retired, what occupation?_________________________________

Substance Use
Tobacco: □Never □2nd hand smoke
□Current user: How many years? ____ Interested in quitting? Y N
□Former user: How many years? ____ What year did you quit? ____
Cigarettes/day: □>40 □ 20-39 □11-19 □1-10 □<1
□E-cigs □Vaping □Cigars □Pipe □Chewing □Snuff

Cannabis (THC/CBD): □Never □Current □Medicinal □Recreational
□Former □Medicinal □Recreational

Frequency : □Daily □2-6 x per week □Weekly □Occasional
Form used: □Smokeable □Edible □Topical

Recreational Drugs: □Never □Current □Former
Frequency of use: □Daily □Weekly □Occasional
Form used: □Cocaine □Ectasy □Meth □Heroin □Amphetamines □Opioids

Do you have a past history of substance abuse? Y N

Caffeine Use: □ No □Yes How many ounces per day? ______
Form used: □Coffee □Tea □Soda □Energy Drink □Chocolate

Alcohol Use: □ No □Daily □ 2-5 days/Week □ once perWeek □Monthly □Rarely

If Beer =12oz, Glass of wine =5 oz, Malt liquor =8 oz & Liquor =1.5 oz per drink
How many drinks do you have on a single day? □<1 □1 □2-3 □4-5 □>5 OR
you can estimate drinks per week □< 7 □7 – 14 □ > 14

How many times per month do you have 5 or more drinks in one day?
□Never □Occasionally □Monthly □2-4 times per month □> 4 times per month

Do you have a history of alcohol abuse? □YES □NO

Physical
Do you exercise? □No □Yes: Minimum 30 minutes non-stop activity? □NO □YES
How often? □Daily □3-5 times /week □1-2 times/week
□Walking □Jogging □Running □Cycling □Other________

Have you been sexually active in the past 12 months? □YES □NO

Do you wear corrective lenses? □No □ Glasses □Contacts

Name: ___________________________________

Do you have difficulty hearing? □No □Conversation in a crowded room
□ On telephones □Background noise □Pain with loud noises
□One-on-One conversation in a quiet room
Do you wear a hearing aid? □Yes □No

Have you fallen in the past 12 months? □No □Once □More than once
Circumstances: □Daytime □Nighttime □Tripping
□Loss of Balance □Vision Problem □Leg Weakness
□Dizziness/Vertigo □Seizure □Loss of Consciousnes
Do you use an assistive device? □No □Straight Cane □Tripod Cane
□Walker □Rolling Walker □Rollator

Any difficulty with sleeping? □No □Going to sleep □Staying asleep □Staying awake
□Daytime sleepiness □Morning headaches □Choking or gasping during sleep
□Snoring □Breathing stops followed by sudden intake

Emotional Health /Family, Home & Community Support

How often during a typical week do you see or talk with family or friends?
□5 or more times □ 3-5 times □1-2 times □< once □monthly □ rarely □never

How often do you feel lonely or isolated from those around you?

□ Never □Rarely □Often □Always

What is your housing situation today? □I have housing □ I live with others

□ live in a facility □No housing

How many family members, including yourself, do you currently live with? ______

If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc, do you get the help you need?

□I don't need any help I get all the help I need □I could use a little help
□I need a lot more help