

SOCIAL HISTORY

NAME: _____ DOB: _____ DATE: _____

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 Ecstasy 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

OVER PLEASE ----->

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 Consciousness

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