Assessment Id: ACJL_600418

Effective Date 10/10

SOCIAL HISTORY ASSESSMENT

Resident Name
Birthdate
External ID (ResID)
Social Security Number
Resident Address Comma Delimited
Date of admission to community _____/_____/_____
Date Admitted
Number of previous admissions to facility
Payment Status at time of assessment
Emergency Contact

Funeral Home information

Financial / POA documents on file ◯ Yes ◯ No
Medical / HCA documents on file ◯ Yes ◯ No
Living Will / Health care instructions on file ◯ Yes ◯ No

Comments

PSYCHOSOCIAL BACKGROUND INFORMATION

Lifetime Occupation
Education
Military Status if applicable ◯ Air Force ◯ Marines ◯ Army ◯ Navy ◯ Coast Guard ◯ Other
Language
Religion
Spirituality
☐ Holocaust Survivor
Registered to Vote ◯ Yes ◯ No ◯ N/A
Current Gender Identity ◯ Male ◯ Female ◯ Transgender ◯ Other (specify below)
Other:
What sex were you assigned at birth? ◯ Male ◯ Female
Preferred Pronoun ◯ Him ◯ Her ◯ Other (specify below)
Other:
Sexual Orientation: ◯ Gay ◯ Lesbian ◯ Bisexual ◯ Heterosexual ◯ Decline to Answer ◯ Other (specify below)

Other:
Comments on psychosocial background information

SUPPORT SYSTEMS

Relationship Status:
☐ Married
☐ Widowed
☐ Single
☐ Divorced
☐ Separated
☐ Never Married
☐ Significant Other
☐ Partner
☐ Other (specify below)

Other:
Length of Marriage(s)
Marriages (1st/ 2nd/ 3rd)
Support Systems for this resident (family, friends, and others)
Caregiver Status

COPING SKILLS

Mental Health History: History of ☐ Anxiety ☐ Depression ☐ Other
Comments regarding mental history

Has resident had any past psychiatric hospitalizations? ○ Yes (proceed to next question) ○ No (skip next question)

If yes, indicate when and diagnosis

Is resident currently taking psychotropic medications? ○ Yes (proceed to next question) ○ No (skip next question)
If yes, indicate medication

Mental health services in place ○ Yes ○ No

Mental Health follow-up or referral needed?

Does resident currently use alcohol, tobacco, etc? ○ Yes (proceed to next question) ○ No (skip next question)
Comments regarding use of alcohol, tobacco, etc.

NARRATIVE SECTION

Summary Notes

DISCHARGE PLANNING

Reason for Admission:

Prior Residence

Is this a long term placement for the resident?
○ Yes, proceed to next section
○ No, proceed to next discharge planning question

Previous discharge services
- ☐ Certified Home Health Nursing
- ☐ Certified Home Rehab
- ☐ Outpatient Rehab
- ☐ Meal carry out / delivery
- ☐ Press to pull / pullcord
- ☐ Housekeeping

Discharge Goals ○ Independent Living ○ Assisted Living ○ Long term care

Discharge Planning Comments regarding resident's family, and Discharge team perception of discharge goals.

Client Goals

Name of Person completing assessment

RE-ADMISSION ASSESSMENT

Re-admission assessment comments

Name of Person completing re-admission assessment