Personal History Snapshot

What you might want to know about me to help me

My Personal Information

Name: _____

Address: _____

_____

Phone Number: Date of Birth:

E-mail: _____

My Insurance Information (Type and ID Number)

1) Medical Assistance/ACCESS: _____

2) Medical Assistance Physical Health Managed Care Organization:

_____

3) Medical Assistance Behavioral Health Managed Care Organization:

_____

4) Medicare: _____

5) Private Insurance: _____

Phone Number: _____

Card Holder Name: _____

Important PEOPLE in my life

Person Who Supports Me: *(This could be next of kin, neighbor, friend or agency staff)*

S/he is my _____

Name: _____

Address: _____

_____

Phone Numbers: Primary: _____ Alternate: _____

E-Mail: _____

My Decision Maker: *(Legal guardian or medical power of attorney)*

Who this person is: _____

Name: _____

Address: _____

_____

Phone Numbers: Primary: _____ Alternate: _____

E-Mail: _____

My Discharge Planning Contact:

Relationship to me: _____

Name: _____

Address: _____

Phone Numbers: Primary: _____ Alternate: _____

E-Mail: _____

Any Other Support Person to Contact in Time of Crisis: *(Friend or other relative)*

S/he is my: _____

Name: _____

Address: _____

_____

Phone Numbers: Primary: _____ Alternate: _____

E-Mail _____

School Name: _____

School Contact: _____ Phone Number: _____

E-Mail: _____

My Doctors:

Name: _____
Address: _____
_____
Phone #: _____
Specialty: _____

Name: _____
Address: _____
_____
Phone #: _____
Specialty: _____

Name: _____
Address: _____
_____
Phone #: _____
Specialty: _____

Name: _____
Address: _____
_____
Phone #: _____
Specialty: _____

Name: _____
Address: _____
_____
Phone #: _____
Specialty: _____

Name: _____
Address: _____
_____
Phone #: _____

Specialty: _____

My Other Supports *(Ex: Case Manager, Supports Coordinator, Behaviorist, Psychologist, Counselor, Physical Therapist, Speech Therapist, Occupational Therapist, Certified Peer Specialist)*

Title: _____
Name: _____
Address: _____
_____
Phone #: _____
E-Mail: _____

Title: _____
Name: _____
Address: _____
_____
Phone #: _____
E-Mail _____

Title: _____
Name: _____
Address: _____
_____
Phone #: _____
E-Mail: _____

Title: _____
Name: _____
Address: _____
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Phone #: _____
E-Mail: _____

Title: _____
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E-Mail: _____

Title: _____
Name: _____
Address: _____
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Phone #: _____
E-Mail: _____

Title: _____
Name: _____
Address: _____
_____
Phone #: _____
E-Mail: _____

Everything you Need to Know to Support Me

My Current Diagnoses that I am being treated for: *(Attach if available, otherwise complete)*
My Brief Medical History *(Please complete or attach narrative)*

Medical: _____
Psychiatric: _____

My Allergies:

My Physical Health Baseline:

When I am well I feel and look

My Behavioral Health Baseline:

When I am well I feel and look

Medications that have **not** worked for me or that are contraindicated:

Medical: _____
Psychiatric: _____

Things that really help me communicate with you :

I have a Behavioral Support Plan (If yes, please attach) Yes ☐ No ☐

The most effective way to communicate with me is: _____

I use Assistive Technology or other ways to help me communicate (if yes, describe) Yes ☐ No ☐

I speak _____ (Spanish, ASL, other) and request an interpreter.

I need additional support with the following things: (Ex: Feeding plans for dysphagia, etc.)

Tips on How to Treat Me Effectively

***I Prefer/Do NOT Prefer getting treatment at the following Hospital(s)*:**

Psychiatric: _____
Medical: _____

My Emotional/Behavioral Triggers Are:

You can help keep me calm using the following techniques:

Other Medical Supports or Equipment I use: *(Wheelchair, hearing aids, etc.)*

WRAP (Wellness Recovery Action Plan), Psychiatric or Medical Advance Directives:

I have formal Plans to help you support me. Yes ☐ No ☐
If yes, please attach

Medications*: (Attach Medication Administration Report or list)*

Name:		Dosage and Frequency:	
Purpose:		Prescriber:	
Name:		Dosage and Frequency:	
Purpose:		Prescriber:	
Name:		Dosage and Frequency:	
Purpose:		Prescriber:	
Name:		Dosage and Frequency:	
Purpose:		Prescriber:	
Name:		Dosage and Frequency:	
Purpose:		Prescriber:	
Name:		Dosage and Frequency:	
Purpose:		Prescriber:	
Name:		Dosage and Frequency:	
Purpose:		Prescriber:	

Pertinent Information

Name:

Communication Ability

- ☐ Speaks few words
- ☐ Good verbal skills
- ☐ No verbal skills
- ☐ Understands speaking
- ☐ Understands gestures
- ☐ Follows simple directions
- ☐ Uses gestures
- ☐ Uses sign language
- ☐ Uses facilitated communication or assistive communication

Typical Behavior

- ☐ Calm
- ☐ Anxious
- ☐ Cooperative
- ☐ Uncooperative
- ☐ Noisy
- ☐ Withdrawn
- ☐ Suspicious
- ☐ Fearful
- ☐ Aggressive
- ☐ Self-abusive

Equipment Use

- ☐ Walker
- ☐ Cane
- ☐ Wheelchair
- ☐ Shower chair
- ☐ Side rails
- ☐ Hearing aid(s)
- ☐ Dentures
- ☐ Glasses
- ☐ Artificial limb
- ☐ Pacemaker
- ☐ Feeding Tube
- ☐ Nebulizer
- ☐ CPAP
- ☐ Other

Explain:

Functional Levels

S = self, A = with assistance,
C = complete care, N = not impaired

Eating
Bathing
Dressing
Mobility

Vision:

Hearing:

Special Diet:

Mealtime modifications
Ordered: ☐ Yes ☐ No
Explain:

Supplements: ☐ G-tube ☐ J-tube ☐ Thickened liquids
Consistency:

Elimination

Bowel

- ☐ Continent
- ☐ Incontinent
- ☐ Occasional incontinence
- ☐ Ostomy

Bladder

- ☐ Continent
- ☐ Incontinent
- ☐ Nightime incontinence
- ☐ Toileting schedule
- ☐ Catheter
- ☐ Ostomy

What interventions help with this individual?

Typical sleep schedule:

- ☐ Sleeps well
- ☐ Sleeps poorly
- ☐ Other: