

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES**  
**SOCIAL HISTORY**

PARTICIPANT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

I. DEVELOPMENTAL HISTORY: Provide information summarizing personal growth from infancy through adolescence with attention to the development of his/her physical, social, and emotional competencies. As outlined below, if development is delayed, describe the circumstances or conditions associated with the delay and date of onset. If more space is needed, use back of this sheet and identify information by Roman numeral and Letter.

a) Physical

b) Social

c) Emotional

II. FAMILY: List parents, spouse, children, siblings, significant others, and type of relationships, i.e., are they an available source of support and/or resources. Include description of family's socio-economic circumstances, and family composition. Past and current living arrangements, special problems, such as alcohol, substance abuse, and mental illness should be included.

- III. EDUCATION/TRAINING: Describe education and training experiences, identify schools and programs attended, relationships with peers and teachers, any adjustment problems, levels of accomplishment and any other pertinent information.
  
- IV. FUNCTIONAL STATUS: Describe levels of functioning relating to employment capabilities, work-related experiences, and assessment of skills relevant to the activities of daily living and self-care skills. Is applicant/participant now or ever been gainfully employed? Indicate level of care recommendation
  
- V. RECREATION/LEISURE ACTIVITIES: Identify and describe recreational and leisure time activities, frequencies, accessibility, and degree of involvement.
  
- VI. HOSPITALIZATIONS: List medical and psychiatric hospital dates and reason for admissions.

_____ I/DD	_____ Heart Disease	_____ Cerebral Palsy
_____ Autism	_____ Diabetes	_____ Tuberculosis
_____ Hepatitis	_____ Mental Illness	_____ Kidney Disease
_____ Cancer	_____ Hypertension	_____ Metabolic Disease
_____ Allergies	_____ Thyroid Disease	_____ Muscular Dystrophy
_____ Epilepsy	_____ Other	_____

Deceased Siblings (Cause of Death) \_\_\_\_\_

VII. LEGAL STATUS: (Guardianship, committee, custody).

VIII. OTHER RELEVANT INFORMATION: (Family medical history; applicant/participant military service; religious preference; or significant events or circumstances not covered in other sections).

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Based on the findings of this assessment, I have determined this individual requires the level of care and active treatment provided in an "INTERMEDIATE CARE FACILITY" for persons with an Intellectual Disability and/or Related Condition.

\_\_\_\_\_ Yes      \_\_\_\_\_ No

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF TEMPORARY LSW

\_\_\_\_\_  
SIGNATURE/CO-SIGN OF DEGREED/LSW

\_\_\_\_\_  
LICENSE #/DEGREE

\_\_\_\_\_  
LICENSE #/DEGREE