RESIDENT - PERSONAL/SOCIAL DATA

(See 22 VAC 40-73-380)

Name:	Admission Date:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Last Home Address:	Address From Which Received (if different):	
Date of Birth: Estimated Age (if DOB unknown):	Birth Place:	Allergies:
Interests/Hobbies:	Lifetime vocation, career or primary role: Service in Armed Forces, if applicable:	Information on advance directives, Do Not Resuscitate (DNR) orders, or organ donation, if applicable:

Legal Representative, if any (attach documents)	Designated Contact Person
Name:	Name:
Address:	Address:
Phone:	Phone:
Cell Phone:	Cell Phone:

Responsible Individual (reg. 550 H), if needed	Clergyman/Place of Worship, if applicable
Name:	Name:
Address:	Address:
Phone:	Phone:
Cell Phone:	Cell Phone:
	Place of Worship:

Next of Kin, if known	Next of Kin, if known
Name:	Name:
Address:	Address:
Phone:	Phone:
Cell Phone:	Cell Phone:

Personal Physician	Personal Dentist
Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Cell Phone:	**Cell Phone:**

Local Department of Social Services, if applicable	Other Agency, if applicable
Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Cell Phone:	**Cell Phone:**
Case Manager or Caseworker:	**Case Manager or Caseworker:**

Previous mental health or intellectual disability services history, if any, and if applicable for care or services:
☐ **Not Applicable** ☐ **Yes, Explain Below**

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Current behavioral and social functioning:____

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Strengths: ____

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Problems: ____

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Substance abuse history if applicable for care or services: ☐ **Not Applicable** ☐ **Yes, Explain Below**

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