Better Communication.
Better Healthcare.

Health Resume For: **Date:**

PATIENT INFORMATION		**CONTACT INFORMATION**
Preferred Name:		Legally Responsible Name:
	Date of Birth:	Relationship of Legally Responsible:
	Sex at Birth: Other	Day Phone of Legally Responsible:
	Current Gender: Other	Night Phone of Legally Responsible:
	Race: Other	Email of Legally Responsible:
	Height:	Address of Legally Responsible:
	Weight:	
	Religion:	
Address:		Additional Contact Name:
		HOUSING
Patient Phone:		Housing Status: Lives Alone
Patient Email:		Residential Service Provider:
Primary Physician:		Monday-Friday Day Hours:
Primary Physician Phone:		Day Contact Name:
Specialist Physician Name:		Day Contact Phone:
Specialist Physician Phone:		Evening Contact Name:
Specialist Physician Specialty:		Evening Contact Phone:

RISKS			**DNR:**	On File A
□Implants	□Pacemaker	□Falls	**ORIENTATION:**	□To Person (knows their name)
□Feeding Tube	□Aspiration	□Seizures		□To Place (knows where they are)
□Bedsores	□VNS			□To Time (knows current day/time)
□Other:			**OXYGEN USE:**	Type: Amount:
CURRENT MEDICATIONS: List Attached			**ALLERGIES:**	List Attached

BRIEF MEDICAL

□Dentures/Dental	□Seizures	□Thyroid Disease	□Other:
□Mental Illness	□Cerebral Palsy	□CPAP	
□Diabetes	□Genital Urinary	□Oxygen	
□ UTI (Urinary Tract Infection)			

PAIN SIGNS	□ SBI (Self-Injury Behavior)	□Crying	□Flinching	□Other:	
	□Fetal Position	□Grimacing	□Screaming		
FEAR SIGNS	□Physical Agitation	□Crying	□Flinching	□Non-Responsive	□Other:
	□Still	□Grimacing	□Screaming	□Rapid Breathing	
ANXIETY TRIGGERS	□Loud Noises	□Touching	□Masks	□Men	□Other:
	□Crowds	□Needles	□Procedures	□Women	
CALMING TECHNIQUES	□Music	□Light	□Books	□Explain Service	□Other:
	□Touch	□Dim Light	□Massage	□Soft Speech	

COMMUNICATION	Primary Language:		□Understands	□Speaks
	Secondary Language:		□Understands	□Speaks
	□Needs Translator	□Sign Language		□Nonverbal Sounds
	□Communication Devices	□Needs Time to Respond		□Other
VISION	Blind	HEARING	Deaf	
MOBILITY	□Independent	□Cane	□Wheel Chair	□Assistive Devices
	□Requires Minimum Assist		□Requires Total Assist	
	□Other:			

Better Communication.
Better Healthcare.

Health Resume For: **Date:**

ACTIVITIES OF DAILY DRESSING AND LIVING			
TOILETING		Dressing	Complete Assist
□Incontinent to Bowel	□Urinal	Bathing	Complete Assist
□Incontinent to Bladder	□Commode	Oral Care	Complete Assist
□Needs Bathroom Assist	□Diapers	Peri-Care	Complete Assist
□Bedpan		Hair Care	Complete Assist
□Other:		Handedness	Right Handed
		Eating	Complete Assist
		Drinking	Complete Assist

DIET & NUTRITION	RESTRICTED FOODS	FAVORITE FOODS/DRINKS
□Regular		
□Soft		
□Puree		
□Chopped		
□Mechanical		
□History of Aspiration		
□Feeding Tube		
□Other:		

CURRENT DAY PROGRAM	FAVORITE ACTIVITIES

INSURANCE INFORMATION		ICD-10 INFORMATION
SSN:		**Intellectual Disability Diagnosis:**
Medicare:	**Medicare Number:**	
Medicaid:	**Medicaid Number:**	
Primary Insurance:		
Primary Policy Number:		**Mental Health Diagnosis:**
Primary Policy Holder Name:		
Secondary Insurance:		
Secondary Insurance Number:		
Secondary Policy Holder Name:		**Other Diagnosis**
Prescription Coverage:		
Other:		

ADDITIONAL INFORMATION

Better Communication.
Better Healthcare.

Health Resume For: **Date:**

FREQUENCY	MEDICATION	FORM (TABLET, LIQUID,ETC)	DOSAGE

KNOWN ALLERGIES

OTHER INFORMATION