MILESTONE, INC.
PSYCHO-SOCIAL INFORMATION

DEMOGRAPHIC REPORT

First Name: ______________________ Date of Birth: ______________________

Middle Name: ______________________ City of Birth: ______________________

Last Name: ______________________ County of Birth: ______________________

SS#: ______________________ State of Birth: ______________________

Nick Name/Alias (if applicable): ______________________

Current Address: ______________________

City/State/Zip: ______________________

Telephone Number: ______________________

Sex: ____________ Race: ____________ Hair Color: ____________

Eye Color: ____________ Height: ____________ Weight: ____________

Marital Status: ____________ Military Service: ____________

Identifying Marks (scars/tattoos/etc.): ______________________

____

Date of Last Psychological: ______________________

Primary Level of Functioning: ______________________
(Example: mild, moderate, severe, profound)

Name of Referring Case Coordination Agency: ______________________

Agency Address: ______________________

City/State/Zip: ______________________

Service Coordinator: ______________________ Telephone: ______________________

CURRENT LEGAL STATUS

Legal Status – check all that apply

☐ Minor ☐ Guardian of Person ☐ Limited Guardianship

☐ Plenary Guardian ☐ Living Will ☐ Durable Power of Attorney

☐ Temporary Guardian ☐ Do Not Resuscitate ☐ Competent

Printed Name of Person Completing Report: ______________________

Relationship: ______________________

Name of Individual: ________________________________

ABUSE AND NEGLECT

A. Does individual have any history of emotional/physical abuse or neglect? YES NO

If <u>NO</u> skip to Question B in this section.

If yes, explain abuse: ____

____

Does the perpetrator have any ongoing contact with the individual? YES NO

If yes, explain:____

Were services accessed in the past for this abuse/neglect? (check all that apply)

- ☐ DCFS
- ☐ Psychiatric
- ☐ other:
- ☐ Psychologist
- ☐ Community Center
- ☐ Professional Counsel
- ☐ Hospitalization

Explain all services that currently apply: ____

____

B. Has the individual ever experienced any type of sexual abuse? YES NO

If <u>NO</u> skip to Question C in this section.

If yes, explain abuse: ____

____

Does the perpetrator have any ongoing contact with the individual? YES NO

Were services accessed in the past for this sexual abuse? (check all that apply)

- ☐ DCFS
- ☐ Psychiatric
- ☐ other:
- ☐ Psychologist
- ☐ Community Center
- ☐ Professional Counsel
- ☐ Hospitalization

Explain all services that currently apply: ____

____

C. Has the individual been accused of being a sexual predator? YES NO

If NO skip to ***Behavior Report*** section.

If yes, explain abuse: ____

____

Does the individual have any ongoing contact with the victim? YES NO

Name of Individual: ______________________________

Were services accessed in the past for this sexual abuse? (check all that apply)

☐ DCFS	☐ Psychiatric	☐ other:
☐ Psychologist	☐ Community Center	
☐ Professional Counsel	☐ Hospitalization	

Explain all services that currently apply: ____

____

BEHAVIOR REPORT

Does the individual currently, or in the past, exhibit any of the following behaviors: (check all that apply)

☐ Physical Aggression	☐ Self Abuse	☐ Property Destruction
☐ Sexual Aggression	☐ Verbal Aggression	☐ Fire Setting

In what situations do you typically observe the individual? (check all that apply)

☐ Self Care Routine	☐ Academic Training	☐ Mealtimes
☐ Leisure Activities	☐ Vocational/Work	☐ Mornings
☐ Evenings	☐ Nothing To Do	☐ Other:

List the aggressive, self-abusive, repetitive and/or maladaptive behaviors that you have observed the individual to exhibit: ☐ = **currently exhibits** (check all that apply) ◇ = **in the past** (check all apply)

☐ ◇ Hit Self	☐ ◇ Hit Others	☐ ◇ Grab Things/Others
☐ ◇ Bite Self	☐ ◇ Pull Others Hair	☐ ◇ Push Things/Others
☐ ◇ Pull Own Hair	☐ ◇ Head Butt	☐ ◇ Threaten Others
☐ ◇ Scratch Self	☐ ◇ Pinch	☐ ◇ Verbal Aggression
☐ ◇ Dig Nails	☐ ◇ Throw Things	☐ ◇ Tease/Provoke
☐ ◇ Bang/Slam Body	☐ ◇ Scratch Others	☐ ◇ Tip Furniture
☐ ◇ Hit Windows	☐ ◇ Tear Objects	☐ ◇ Make Noises
☐ ◇ Rip Clothing	☐ ◇ Spitting	☐ ◇ Picking Things/Others
☐ ◇ Rocking	☐ ◇ Kick	☐ ◇ Bite Others
☐ ◇ Hand/Finger Waving	☐ ◇ Object Twirling	☐ ◇ Elopement
☐ ◇ Mouthing Hand/Objects	☐ ◇ Inserting Objects into Body	

Do behaviors occur when person is seeking attention? YES NO

Is behavior accompanied by other emotional responses (yelling, crying, etc.)? YES NO

What approach do you use to address the behavior (comfort, ignore, reason, etc.)? ________________

____

____

____

Name of Individual: ________________________

What do you believe are the causes for the behavior(s) that the individual currently exhibits: (check all that apply)

☐ Upset	☐ Mealtimes	☐ Attention Seeking
☐ Tired	☐ Request to Stop	☐ Work Demands
☐ Mimic	☐ Constipated	☐ Requests
☐ Under-stimulated	☐ Self Care Demands	☐ Stop Leisure Activity
☐ Hungry	☐ Bored	☐ Academic Demands
☐ Angry	☐ Transitions	☐ Wants Items
☐ Over-stimulated	☐ Frustrated	☐ Other

Do you use reinforces for positive behaviors (treat, special item, etc.)? YES NO

If YES, describe reinforcement: ____

____

Does this individual approach you or others to initiate social interactions? YES NO

Is this individual responsive to social stimulation? YES NO

Do behavior(s) occur more when the individual is ill? YES NO

Does this individual have a history of recurrent illness? YES NO

☐ Ear Infections	☐ Dermatitis	☐ Sinus Infections
☐ Allergies	☐ Urinary Infections	☐ Other

Does this individual communicate when she/he is ill? YES NO

If YES, describe how: ____

____

____

COMMUNICATION REPORT

How does this individual communicate: (check all that apply):

☐ Verbal	☐ Communication Book	☐ Communication Board
☐ Non-verbal	☐ Sing Language	☐ Touch Talker
☐ Gestures	☐ Other ________________________	

What is/are this individual's primary language(s): (check all that apply)

UNDERSTOOD	SPOKEN
☐ English	☐ English
☐ Spanish	☐ Spanish
☐ Chinese	☐ Chinese
☐ Japanese	☐ Japanese
☐ Russian	☐ Russian
☐ Other______________	☐ Other______________

Name of Individual: ________________________

What is the family/guardian's primary language(s): (check all that apply)

	UNDERSTOOD		SPOKEN
☐	English	☐	English
☐	Spanish	☐	Spanish
☐	Chinese	☐	Chinese
☐	Japanese	☐	Japanese
☐	Russian	☐	Russian
☐	Other______________	☐	Other______________

What resources has the individual used to effectively communicate? (check all that apply)

☐	Communication Board	☐	Picture Board	☐	Facilitated Communication
☐	Sign Language	☐	Gestures	☐	Touch Talker
☐	No Resources	☐	Other ______________________________		

What resources have been tried in the past and HAVE NOT been successful? (check all that apply)

☐	Communication Board	☐	Picture Board	☐	Facilitated Communication
☐	Sign Language	☐	Gestures	☐	Touch Talker
☐	No Resources	☐	Other ______________________________		

If NOT successful, please explain: ____

____

CULTURE REPORT

What are the family/guardian's cultural practices for…

Holidays: ____

____

Clothing: ____

____

Foods: ____

____

Hair: ____

____

Medical: ____

____

Communication: ____

____

Other: ____

____

Name of Individual: ________________________

What are the individual's cultural practices:

Holidays: ____

____

Clothing: ____

____

Foods: ____

____

Hair: ____

____

Medical: ____

____

Communication: ____

____

Other: ____

____

DEVELOPMENTAL HISTORY

Was there anything abnormal about the pregnancy or birth? YES NO

Please describe: ____

____

____

At what age was the disability first noticed: ____

What lead you to believe that individual was disabled? ______________________________________

____

Developmental milestones (please indicate age at which the following were achieved):

____________ Walked ____________ Fed Self ____________ First Word

____________ Used Sentences ____________ Toiler Trained ____________ Dresses Self

EDUCATIONAL/VOCATIONAL REPORT

Did your individual receive early intervention services? YES NO

Name of Individual: ________________________

If YES, list the name and address of the school/program for early intervention services:

Name: ____

Address:_______________________________________

Dates Attended:___________to__________

List the three previous schools attended:

Name: __________________________________ Date attended_____________to__________

Address: ____

Name: __________________________________ Date attended_____________to__________

Address: ____

Name: __________________________________ Date attended_____________to__________

Address: ____

What type of classes does/did this individual attend while in school?

☐ = **currently attends** (check all that apply) ◇ = **attended in the past** (check all that apply)

☐ ◇ Self-contained Special Education School
☐ ◇ Self-contained Special Education Classroom
☐ ◇ Regular Classroom – No Special Education
☐ ◇ Regular Classroom – Inclusion
☐ ◇ Learning Disabled
☐ ◇ Behavioral Class
☐ ◇ Other: ____

What services have/ are being provided by the schools: (check all that apply)

☐ = **currently receives** ◇ = **received in the past**

☐ ◇ Speech/Language ☐ ◇ Vocational ☐ ◇ Physical Therapy
☐ ◇ Vision ☐ ◇ Audiological ☐ ◇ Occupational Therapy
☐ ◇ Other: ____

Has this individual had a vocational assessment completed/work in a vocational setting? YES NO

Are there vocational skills this individual can perform/enjoys performing (may or may not do well)?

☐ = **can perform** (check all that apply) ◇ = **enjoys doing** (check all that apply)

☐ ◇ Make Bed ☐ ◇ Clear Table ☐ ◇ Fold Laundry
☐ ◇ Sweep/Vacuum ☐ ◇ Wash/Dry Dishes ☐ ◇ Sorting
☐ ◇ Set Table ☐ ◇ Dusting ☐ ◇ Put Object Together
☐ ◇ Cleaning ☐ ◇ Do Laundry ☐ ◇ Other

Name of Individual: ________________________

FAMILY/GUARDIAN GOALS & OBJECTIVE REPORT

What does the family believe are this individual's greatest needs: ______________________________
____
____
____
____

What circumstances have occurred that have led the family/guardian to seek residential placement:
____
____
____

What is/are the family/guardian's hopes for the individual's future: ____________________________
____
____
____

What is/are the family/guardian's expectations regarding services for this individual from this facility:
____
____
____
____
____

FAMILY REPORT

<u>Father's Information</u>

Name: ___________________________________ Date of Birth: ________________________

Address: _________________________________ SS#: ______________________________

City/State: _______________________________ Home Phone: _________________________

Zip: ____________________________________ Work Phone: __________________________

Marital Status: ____________________________ Cell Phone: ___________________________

Legal Status (if applicable) ___________________ Pager Number: ________________________

City/State of Birth: __________________________ County of Birth: _______________________

Name of Individual: ___________________________

<u>Mother's Information</u>

Name: ____ Date of Birth: ___________________________

Address: ______________________________________ SS#: ___________________________________

City/State: ____________________________________ Home Phone: ___________________________

Zip: ____ Work Phone: ___________________________

Marital Status: _________________________________ Cell Phone: ____________________________

Legal Status (if applicable) ______________________ Pager Number: _________________________

City/State of Birth: _____________________________ County of Birth: ________________________

Are biological parents currently married to each other? YES NO

If divorced are there step-parents? YES NO

Sibling Information

Name of Sibling(s)	Date of Birth	Relationship
_________________________	__________	____________________
_________________________	__________	____________________
_________________________	__________	____________________
_________________________	__________	____________________
_________________________	__________	____________________
_________________________	__________	____________________

Emergency Contact Information:

Contact Person: ________________________________ Relationship: ____________________

Address: ______________________________________ Home Phone: ____________________

City/State: ____________________________________ Work Phone: ____________________

Zip: ____ Cell Phone: _____________________

Significant Other Information (including siblings not living at home):

Name: ____ Relationship: ____________________

Address: ______________________________________ Home Phone: ____________________

City/State: ____________________________________ Work Phone: ____________________

Zip: ____ Cell Phone: _____________________

Name of Individual: ___________________________

Name: ____ Relationship: ____________________

Address: ______________________________________ Home Phone: ____________________

City/State: ____________________________________ Work Phone: ____________________

Zip: ____ Cell Phone: ______________________

Name: ____ Relationship: ____________________

Address: ______________________________________ Home Phone: ____________________

City/State: ____________________________________ Work Phone: ____________________

Zip: ____ Cell Phone: ______________________

FINANCIAL REPORT

The following questions are for Social Security and Public Aid purposes only. All applicants have the right to reasonable access to care regardless of financial standings.

Does this individual receive:

SSI?	YES	NO	Amount: ___________
SSDI?	YES	NO	Amount: ___________
SSA?	YES	NO	Amount: ___________
Child Support	YES	NO	Amount: ___________

Does the individual have any of the following assets: (check all that apply)

☐ Stocks	☐ Home	☐ Savings Account
☐ Bonds	☐ Burial Insurance	☐ Checking Account
☐ Land/Property	☐ Life Insurance	☐ Other:

DPA Number: _________________________________

RIN Number: _________________________________

On "Spend Down" Status: YES NO

Medical Insurance: YES NO

Name of Insurance Company: ____

Address: ______________________________________ Phone Number: __________________

City/State: ____________________________________

Zip: ____

HMO: ______________ PPO: _______________ Other: ______________

Policy Number: _______________________________ Group Number: __________________

Family Member Providing Insurance: ____

Name of Individual: ________________________

Is This Employment Insurance? YES NO

Does the insurance include: (check all that apply)

☐ General Medical	☐ Prescription	☐ Other
☐ Dental	☐ Vision	

INDIVIDUAL PREFERENCES & SPECIAL NEEDS REPORT

What are the individual's <u>LIKES</u>?

Things to do/Activities: ____

____

Places to go: ____

____

Toys/Objects: ____

____

People: ____

____

Foods: ____

____

What are the individual's <u>DISLIKES</u>:

Things to do/Activities: ____

____

Places to go: ____

____

Toys/Objects: ____

____

People: ____

____

Foods: ____

____

Name of Individual: ________________________

What are the sensory LIKES of the individual: (check all that apply)

☐ Soft Objects	☐ Smooth Objects	☐ Brushing
☐ Rock	☐ Rough Objects	☐ Strong Smells
☐ Hum	☐ Light Pressure	☐ Light
☐ Loud Noises	☐ Deep Pressure	☐ Other
☐ Fans	☐ Vibration	

What are the sensory DISLIKES of the individual: (check all that apply)

☐ Soft Objects	☐ Smooth Objects	☐ Brushing
☐ Rock	☐ Rough Objects	☐ Strong Smells
☐ Hum	☐ Light Pressure	☐ Light
☐ Loud Noises	☐ Deep Pressure	☐ Other
☐ Fans	☐ Vibration	

What is the family's religion: ______________________________

What is the individual's religion: ___________________________

In order to accommodate specific religious needs please specify needs: ___________________________

____

SEXUALITY REPORT

Does this individual express his/her sexuality? YES NO

If yes, how does the individual express his/her sexuality: ______________________________________

____

Has this individual expressed a sexual preference? YES NO

If yes, what is the sexual preference: ____

Does the family/guardian support the individual's sexuality? YES NO

Additional Comments: ____

____

____

Name of Individual: ______________________________

SOCIAL SKILLS REPORT

What are the family activities: (check all that apply)

☐	Go to Movies	☐	Cards/Games	☐	Talking
☐	Go to Parks	☐	Rent Movies	☐	Read Books
☐	Vacations	☐	Picnics/Cook Outs	☐	Libraries
☐	Visit Friend/Family	☐	Church	☐	Museums/Civic Centers
☐	Swimming	☐	Amusement Parks	☐	Carnivals
☐	Sports	☐	Restaurants	☐	Go Shopping
☐	Video Games	☐	Other ______________________________		

Check all the social skills the individual exhibits: (check all that apply)

☐	Likes to play with peers	☐	Smiles	☐	Shares personal items
☐	Visits with Others	☐	Holds Conversations	☐	Shake Hands
☐	Takes Turn in Conversations	☐	Other ______________________________		

Check all of the experiences this individual has had in the community: (check all that apply)

☐	Grocery Store	☐	Malls	☐	Hospitals
☐	Church	☐	Restaurants	☐	Doctor's Office
☐	Parks	☐	Salon/Barbershop	☐	Dentist's Office
☐	Museums	☐	Laundry Mat	☐	Other

Check any organized group to which this individual belongs: (check all that apply)

☐	Boy Scouts	☐	Girl Scouts	☐	4-H Club	☐	Other
☐	Sports Team	☐	Church Group	☐	Special Olympics		

Other Comments Regarding Social Skills: ______________________________

____

____

____

____

STRENGTHS AND NEEDS REPORT

What are this individual's strengths: ______________________________

____

____

____

Name of Individual: ________________________________

What are this individual's needs: ____

____

____

____

Questions to be answered for individuals seeking placement at RocVale Children's Home ONLY.

What is the annual financial income of the family household:

☐	Under $10,000	☐	$41,000 - $55,000
☐	$10,000 - $25,000	☐	$56,000 - $70,000
☐	$26,000 - $40,000	☐	$71,000 or Above

Custodial Parent/Guardianship Report

If child is under are 18 and parents are divorced, who is custodial parent:

____

If your individual in under 18 years of age, who do you anticipate will become legal guardian?

Name: ____ Relationship: ____________________

Address: ______________________________________ Home Phone: ____________________

City/State: ____________________________________ Work Phone: ____________________

Zip: ____ Cell Phone: _____________________

SS#: ____ Date of Birth: ___________________