Step By Step
Supportive Services

Please send completed forms to:
Step By Step Attn: Intake
1470 Beacon Street, Suite B, Brookline, MA 02446
617-277-6140 (P) 617-277-0168 (F)
Please call or e-mail referralinfo@stepbystepss.org
With any additional questions

Family History Application

A family member of the applicant should fill out this form

Applicant Name: _____
Age: _____ DOB: ____/____/____ SS#: _____/_____/_____
Address: _____
Phone: _____ E-mail:_____
Current living situation: _____

Primary person making referral:
Name: _____Relationship: _____
Address_____
Phone: _____ Age_____ E-mail: _____
Quality of Relationship: _____

Family Members:
Name: _____Relationship: _____

Address_____
Phone: _____ Age_____ E-mail: _____
Quality of Relationship: _____

Name: _____Relationship: _____
Address_____
Phone: _____ Age_____ E-mail: _____
Quality of Relationship: _____

Name: _____Relationship: _____
Address_____
Phone: _____ Age_____ E-mail: _____
Quality of Relationship: _____

Name: _____Relationship: _____
Address_____
Phone: _____ Age_____ E-mail: _____
Quality of Relationship: _____

Significant others not listed above:
Name: _____Relationship: _____
Address_____
Phone: _____ Age_____ E-mail: _____
Quality of Relationship: _____

Who maintains a close relationship with the applicant?

_____

Frequency of contact:

_____

Identify your concerns or reasons for the referral:

_____

_____

_____

_____

_____

What would you like your family member to be able to achieve?

_____

_____

_____

_____

_____

_____

_____

Please describe strengths the applicant possesses:

_____

_____

_____

_____

_____

_____

_____

_____

Please describe limitations or struggles the applicant has with regard to reaching his/her goals:

_____

_____

_____

_____

_____

_____

When did the family first begin to notice behaviors, which may be related to the disability?

_____

_____

_____

_____

What were significant events in the lives of your family members?

_____

_____

_____

_____

_____

_____

_____

Were there any traumatic events?

_____

_____

_____

_____

Were there any medical problems, if so please describe?

_____

_____

_____

_____

Were there any serious accidents, if so please describe?

_____

_____

_____

_____

Has the applicant ever suffered a head injury?_____

Is there any other history of disabilities in the family, if so who?

_____

_____

_____

_____

Are there any other family members with special needs?

Is there any history of drug or alcohol abuse for any individual in the family?

Describe mental health services sought, provided by whom, what was purpose or goal, what was helpful for the person or the family:

Describe the need for hospitalizations, where, when, for how long, and what led up to each hospitalization:

History of residential placements:

What problems are facing the family now?

Can the family work with Step By Step while the applicant is in our program?

_____

_____

Does everyone in the family agree with this? _____

What is the best way to communicate with the family? ____Phone ____E-mail ____Meetings

Who would you like to be the primary person of contact? _____

Are there issues the family cannot discuss, are afraid to discuss or don't want to discuss. Does everyone in the family agree with this?

_____

_____

_____

_____

Is there any healing that would be helpful to the family? If so who was or is hurt and how did it occur? _____

_____

_____

_____

Sexual history/Concerns of the applicant:

_____

_____

_____

_____

To what extent does the family or applicant consider spirituality or religion important to their lives? _____

_____

_____

_____

Are there any significant cultural or ethnic issues?

_____

_____

_____

_____

_____

_____

Please provide a history of the educational experiences for the applicant (if possible, enclose a resume):_____

_____

_____

_____

_____

_____

Please provide a history of the vocational or work experiences for the applicant:

_____

_____

_____

_____

Is there any history of learning disabilities? _____

Is there any military history? _____
If yes, did the applicant see any action in the military, receive any benefits?

_____

_____

Please provide any legal history that might be of significance:

Police involvement /Law violations (what, when, outcome):

_____

_____

_____

_____

Legal charges, etc:_____

_____

Incarcerations etc: _____

_____

Civil proceedings: _____

_____

Is there a legal guardian? If so please provide name, address & phone:

_____

_____

_____

_____

Please list any placements or treatment for substance abuse:

_____

_____

_____

_____

When was the last known use of intoxicants? _____

Name specific intoxicants:

_____

_____

_____

_____

Please identify any problems in the following areas:

Nutrition/Eating patterns, changes, disorders:

_____

Pain Management: _____

Depressed Mood/sad: _____

Anxiety: _____

Traumatic Stress: _____

Anger/Aggression: _____

Oppositional Behaviors: _____

Inattention/ Withdrawal: _____

Impulsivity: _____

Disturbed Reality Contact (psychosis): _____

Unusual Thoughts:_____

Mood Swings/Hyperactivity: _____

Substance Abuse/Addiction: _____

Sleep Problems: _____

Social Stressors: _____

Pertinent Health Concerns: _____

Would you consider the applicant to be at risk of harming themselves or others? _____

If yes, please explain:

_____

_____

_____

_____

_____

_____

Is the applicant allergic to any foods?_ _____
If so, please list: _____

Does the applicant have any dietary restrictions? _____
If so please describe: _____

_____

_____

How will SBS know if the applicant is not doing well?

_____

_____

_____

_____

Are there other areas that are important for the staff to understand about the person who may receive SBS support?

_____

_____

_____

_____

Signature: _____ Date: _____

Print Name: _____

Relationship to Applicant: _____