# Recent Stressors Questionnaire

*This assessment was adapted from the UMass Recent Stressors Questionnaire originally developed at the*

*University of Massachusetts by Lauren R. Charlot, PhD, LICSW*

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| **Individual’s Name:** |  | **ID:** |  |
| **Completed upon:** | Initial  Review  Crisis | **Date:** |  |

*Please check YES or NO for each item and describe any item answered YES. Please give details, dates if possible.*

**Which of the following have occurred in the past six months?**

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| Changes in residential staff |  | Yes |  | No |

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| Changes in school or day/vocational staff |  | Yes |  | No |

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| A move to a new living situation |  | Yes |  | No |

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| A change in day program, job, or schools/classroom assignment |  | Yes |  | No |

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| Changes in the level or rate or type of contacts with family or significant people |  | Yes |  | No |

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| Illness of a loved one, caretaker, friend, or peer |  | Yes |  | No |

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| Death of a loved one, caretaker, friend, or peer |  | Yes |  | No |

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| New peers at day/school residence, or loss of peers from these settings |  | Yes |  | No |

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| New task demands |  | Yes |  | No |

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| Housemate having problems/issues |  | Yes |  | No |

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| Family member or close friend having problems |  | Yes |  | No |

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| A new medical problem was identified |  | Yes |  | No |

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| A new medication was started |  | Yes |  | No |

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| A medication was changed (increased or decreased) |  | Yes |  | No |

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| An old health problem worsened recently |  | Yes |  | No |

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| New Behavior Support Plan |  | Yes |  | No |

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| Changes made in the Behavior Support Plan |  | Yes |  | No |

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| Staff may not have been following the BSP consistently |  | Yes |  | No |

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| There was suspected abuse |  | Yes |  | No |

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| Vision or hearing loss or change |  | Yes |  | No |

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| Loss of mobility or decreased mobility |  | Yes |  | No |

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| Changes in doctors, therapists, teachers, or other key service providers |  | Yes |  | No |

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| Things are different at home, work, or school |  | Yes |  | No |

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| The Individual seems as if he/she might be ill, in pain, or uncomfortable |  | Yes |  | No |

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| Changes in bowel or bladder habits (new incontinence other changes in habits) |  | Yes |  | No |

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| Weight loss or weight gain. Change in appetite or start of a new diet |  | Yes |  | No |

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| Changes in sleep pattern |  | Yes |  | No |

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| New onset of falling OR Changes in gait |  | Yes |  | No |

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| Any new or unusual movements of any kind |  | Yes |  | No |

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| Other changes in routines, even small, that might affect this person |  | Yes |  | No |

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| Limited or no un-paid natural supports that help with support |  | Yes |  | No |

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| Hospitalizations |  | Yes |  | No |

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| Has the person been victim of any form of abuse? |  | Yes |  | No |

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| Other: |  | Yes |  | No |

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Signature Date

Print Name & Position: