I-START Program
3 Fourth St. Northeast
Mason City, IA 50401
Phone: 641.525.0401 | Fax: 641.201.3992
Email: istart@countysocialservices.org
www.countysocialservices.org

UMASS Recent Stressors Questionnaire

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?

Changes in residential staff ☐ Yes ☐ No

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

A move to a new living situation ☐ Yes ☐ No

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

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

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

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

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

New task demands ☐ Yes ☐ No

Housemate having problems/issues ☐ Yes ☐ No

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Family member or close friend having problems ☐ Yes ☐ No

A new medical problem was identified ☐ Yes ☐ No

A new medication was started ☐ Yes ☐ No

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

An old health problem worsened recently ☐ Yes ☐ No

New Behavior Support Plan ☐ Yes ☐ No

Changes made in the Behavior Support Plan ☐ Yes ☐ No

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

There was suspected abuse ☐ Yes ☐ No

Vision or hearing loss or change ☐ Yes ☐ No

Loss of mobility or decreased mobility ☐ Yes ☐ No

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

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

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

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

Changes in sleep pattern ☐ Yes ☐ No

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

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

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

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

Hospitalizations ☐ Yes ☐ No

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

Other: ☐ Yes ☐ No

Signature Date

Print Name & Position: