

# Side By Side Supported Living, Inc. Family History

FORM B

**Instructions:** A family member of the applicant should fill out this form and return to:  
SIDE BY SIDE SUPPORTED LIVING, INC., 1470 Beacon Street, Suite B, Brookline, MA 02446.

Applicant Name: \_\_\_\_\_

Age: \_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ E-mail: \_\_\_\_\_

Current living situation: \_\_\_\_\_

### Primary person making referral:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ E-mail: \_\_\_\_\_

Relationship: \_\_\_\_\_

### Family members:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ E-mail: \_\_\_\_\_

Age: \_\_\_\_ Quality of Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ E-mail: \_\_\_\_\_

Age: \_\_\_\_ Quality of Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ E-mail: \_\_\_\_\_

1470 Beacon Street, Suite B  
Brookline, MA 02446

Phone: (617) 277-6140

Fax: (617) 277-0168

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Significant others not listed above:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

Age: \_\_\_\_\_ Quality of Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

Age: \_\_\_\_\_ Quality of Relationship: \_\_\_\_\_

Who maintains a close relationship with the applicant? \_\_\_\_\_

Frequency of contact: \_\_\_\_\_

Identify your concerns or reasons for the referral:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were there any traumatic events? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Were there any medical problems, if so please describe? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Were there any serious accidents, if so please describe? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What problems are facing the family now? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Can the family work with Side by Side while the applicant lives at his/her current address? \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does everyone in the family agree with this? \_\_\_\_\_

What is the best way to communicate with the family? \_\_\_ Phone \_\_\_ E-mail \_\_\_ Meetings

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? \_\_\_\_\_

\_\_\_\_\_

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

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Please describe strengths the applicant possesses: \_\_\_\_\_

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

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Sexual history/Concerns of the applicant: \_\_\_\_\_

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

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Are there any significant cultural or ethnic issues? \_\_\_\_\_

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

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

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Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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? \_\_\_\_\_

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

Does the applicant have any dietary restrictions? \_\_\_\_\_ if so please describe: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

History of residential placements: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_