Our Mission

Our mission is to create a person-centered system of care that is directed by the principles of recovery & trauma informed care. These principles help create an environment that is free from violence and coercion facilitating increased safety and resiliency throughout the hospital admission and upon return to the community.

Please take a moment to complete the following questionnaire. This information will help us to better understand your unique needs and to provide you with the best possible care.

Triggers: What are some of the things that make you angry, very upset or cause you to go into crisis?

- Being touched
- People in uniform
- Yelling
- Bedroom door open
- Darkness
- Sudden movements
- Being restrained
- Auditory and/or visual hallucinations
- Not having control/choices/input (Explain)
- Contact with family or person who is upsetting
- Nightmares/distressing thoughts at night. If so, what?

Other:

Warning Signs: What are your warning signs when you feel you may lose control?

- Sweating
- Crying
- Being Rude
- Loud Voice
- Having bad thoughts about myself or others

Other:

Crisis Prevention Strategies:

It is helpful for us to be aware of things that help you feel better when you are having a hard time. Please indicate if any of the following have ever worked for you.

- Listen to music
- Relaxation tapes
- Warm or cold drink
- Sound machines
- Writing a letter
- Reading (What?)
- Rocking chair/glider
- Voluntary time in the quiet room
- Bean bag tapping/brushing
- Lying down with cold face cloth
- Wrap up tight with sheet/thin blanket
- Doing artwork (painting, drawing)
- Voluntary time in room

- Pacing in the halls
- Dark room (dimmed lights)
- Talking to staff
- Medication
- Lettering with peers on unit
- Aromatherapy
- Calling a friend/family member
- Hot balls/sour candy
- Putting hands in cold water
- Voluntary time in sensory room with staff
- Deep breathing/mindfulness exercises
- Using ice (How?)

Other? (Please list)
Medical Conditions:
Do you have any physical conditions, disabilities, or medical problems such as asthma, high blood pressure, back problems, etc. that we should be aware of when caring for you during an emergency situation?
☐ Yes  ☐ No Explain if yes: _______________________________ ____________________________________

Trauma History:
Do you have a history of sexual abuse or other type of trauma, in childhood? ☐ Yes  ☐ No
Or as an adult?  ☐ Yes  ☐ No  Is abuse still occurring now? _______________________________ ____________________________________
What type(s) of abuse or trauma have you experienced?  ☐ Sexual  ☐ Emotional abuse  ☐ Physical abuse
☐ War  ☐ Incarceration  ☐ Other? _______________________________ ____________________________________
Describe briefly (if able to):__________________________________________________________

Do you have a history of:
☐ Losing control  ☐ Feeling unsafe  ☐ Suicidality  ☐ Self injurious behaviors
☐ Assultive behavior  ☐ Abusive towards other people  ☐ Restraint or seclusion
Describe: ____________________________________________ ______________________________________

Seclusion and Restraint:
Have you ever been placed in a seclusion room?  ☐ Yes  ☐ No
Have you ever been restrained?  ☐ Yes  ☐ No  If yes? When____________________ Where?____________________
What Happened? ____________________________________________ ______________________________________
Have you ever been given medication as an injection that was forced on you?  ☐ Yes  ☐ No
If yes? When?____________________ Where?____________________
What happened? ____________________________________________ ______________________________________

In Extreme Emergencies:
How can you help us avoid restraint/seclusion? _______________________________________
In emergencies, some things that are utilized include:  ☐ Sensory room  ☐ Quiet room  ☐ Your room
☐ Weighted blanket  ☐ Aromatherapy  ☐ Talking to staff  ☐ Medication by mouth
☐ Emergency injection  ☐ Other: ______________________________________________________

Medications:
We may be required to give medications if other measures do not help you to remain safe and in control. In this case, we would like to know what medications have been especially helpful to you. Please describe:
________________________________________________________
________________________________________________________
Are there any medications that are not helpful?  ☐ Yes  ☐ No  If yes, why were the medications not helpful?
Is there anything else that would make your hospitalization better? ___________________________

_________________________________________________________________
_________________________________________________________________

PATIENT SIGNATURE   STAFF SIGNATURE   DATE

If not completed on admit, why? _____________________________ Date/Time: ____________