HISTORY OF TRAUMA CARE PLAN

Date	My Preferences and Needs
_/_/_	A history of trauma affects me negatively. (Describe trauma): _____ _____ _____ _____ *Triggers that have the potential to re-traumatize me include (describe):* ☐ Sound: _____ ☐ Smell: _____ ☐ Touch: _____ ☐ Taste: _____ ☐ Sight: _____ ☐ Other: _____ ☐ Other: _____ *Once I have experienced a trigger, I may display these signs/symptoms (describe as needed):* ☐ Anxiety/Edginess: _____ ☐ Overwhelming fear: _____ ☐ Anger/Irritability: _____ ☐ Changes in mood state: _____ ☐ Nightmares: _____ ☐ Change in sleep patterns: _____ ☐ Confusion/Disorientation: _____ ☐ Pain/Achiness: _____ ☐ Muscle Tension: _____ ☐ Extreme alertness/Hypervigilance: _____ ☐ Withdrawal/Avoidance of activities: _____ ☐ Other: _____ ☐ Other: _____

Date	My Goals	Target Date
_/_/_	☐ Staff will assist me in avoiding my triggers through next review. ☐ The frequency or severity of my trauma-related signs and symptoms will not increase through next review. ☐ _____ _____ ☐ _____ _____	_/_/_

Resident Name:	Room #:	Medical Record #:

HISTORY OF TRAUMA CARE PLAN

Date	Support I Need	Discipline
_/_/_	☐ Staff will assist me with recovery and avoid re-traumatization by: o Know what my triggers are o Keeping me informed about changes to my care, life at the facility, etc. o Monitoring my physical health o Providing me with meaningful activities o Encourage me to be as independent as possible o Encouraging relationships with my family and friends that support me o Respecting my personal space o Administering medications as ordered	ALL
	☐ Arrange for me to receive services from a Licensed Mental Health Provider as indicated.	SS/NSG
	☐ Assist me in attending a support group for trauma survivors if I desire.	SS
	☐ Provide a quiet, non-threatening environment with decreased stimulation for me.	ALL
	☐ Monitor for signs and symptoms of depression, anxiety, sleep disturbances, and substance abuse issues.	SS/NSG
	☐ Encourage and empower me to be involved in my own care.	ALL
	☐ Encourage me to express my feelings/concerns/thoughts in a safe space.	SS
	☐ Identify items that lessen the effects of trauma and provide me comfort.	ALL
	☐ _____ _____	
	☐ _____ _____	

Resident Name:	Room #:	Medical Record #: