



Person's Name (First MI Last):	Record #:
Organization Name:	
Trauma History (Describe in comments section each element checked)	
Comments: (Include single event versus sustained and if information came from collateral source):	
<input type="checkbox"/> Physical Abuse	
<input type="checkbox"/> Domestic Violence/Abuse	
<input type="checkbox"/> Elder Abuse	
<input type="checkbox"/> Financial Abuse	
<input type="checkbox"/> Community Violence	
<input type="checkbox"/> Physical Neglect	
<input type="checkbox"/> Verbal/Emotional Abuse	
<input type="checkbox"/> Sexual Abuse/Molestation	
<input type="checkbox"/> Military Trauma	
<input type="checkbox"/> Other Trauma	
<input type="checkbox"/> Witness to Violence	
<input type="checkbox"/> Other (what does person identify as traumatic for them?)	
Current Involvement by: <input type="checkbox"/> None Reported <input type="checkbox"/> Department of Children and Families <input type="checkbox"/> Disabled Person's Protection Commission <input type="checkbox"/> Elder Affairs <input type="checkbox"/> Other: _____ Comments: _____	
Additional Mandated Report Required?: <input type="checkbox"/> None <input type="checkbox"/> Department of Children and Families <input type="checkbox"/> Disabled Person's Protection Commission <input type="checkbox"/> Elder Affairs <input type="checkbox"/> Other: _____ Comments: _____	

Provider - Print Name/Credential:	Date:	Supervisor - Print Name/Credential (if needed):	Date:
Provider Signature:	Date:	Supervisor Signature (if needed):	Date:
Person's Signature (Optional, if clinically appropriate):	Date:	Parent/Guardian Signature (If appropriate):	Date: