Central State Hospital
620 Broad St.
Milledgeville, GA 31062

# PERSONAL SAFETY INTERVIEW

Individual's Identification

***Instructions:* Interview individual to complete this form or provide form to individual to complete (if preferred).**

**1. Calming Strategies: It is helpful for us to be aware of things that help you feel better when you're having a hard time. Please indicate activities that have worked for you, or that you believe would be the most helpful to you:**

| | | | | | |
|---|---|---|---|---|---|
| Voluntary alone time in your room | ❒ | Deep breathing exercises | ❒ | Reading a book | ❒ |
| Quiet time | ❒ | Wrapping up in a blanket | ❒ | Watching TV | ❒ |
| Sitting by the nurses station | ❒ | Listening to music | ❒ | Pacing the halls | ❒ |
| Talking with another individual | ❒ | Going for a walk with staff (if privileges allow) | ❒ | Exercise | ❒ |
| Talking with staff | ❒ | Putting hands in cold water | ❒ | Taking a shower | ❒ |
| Punching a pillow | ❒ | Putting ice on wrists | ❒ | Other (Please List): | |
| Writing in a diary/journal | ❒ | Writing on arm with red marker | ❒ | | |
| Calling a friend or family member | ❒ | Lying down with cold face cloth | ❒ | | |

**2. What are some of the things or "triggers" that make you angry or very upset that may cause you to escalate?**

| | | | | |
|---|---|---|---|---|
| Being touched | ❒ | Bedroom door open | ❒ | Particular time of day (When?) |
| Loud noise | ❒ | Being isolated | ❒ | Time of year (When?) |
| People in uniform | ❒ | | | Being around ❒ Men ❒ Women |
| Not having control (Explain): | | | | |
| Other (Please list): | | | | |

**3. Do you have preferences or concerns regarding who serves you (such as gender, race, language, culture)? If yes, describe:**____________________

**4. How would I know if you are getting upset?** ____________________

**5. Seclusion and Restraint:**

Have you ever been placed in a seclusion room? ☐ Yes ☐ No Have you ever been restrained? ☐ Yes ☐ No

If yes, what led up to the incident(s)? Tell me about the experience(s) for you.____________________

**6. Is there anything you find helpful in emergency situations that could prevent seclusion or restraint being used? If yes, describe:**____________________

**7. Do you have any medical conditions or physical disabilities and limitations that may place you at risk if seclusion or restraint is used? If yes, describe:** ____________________

**8. If you have to be placed in seclusion or restraint to help keep you and others safe, would you want us to notify someone? If yes, what is that person's name and telephone number and his/her relationship to you?**

____________________

**9. Does it bother you if people get close to you and touch you?** ☐Yes ☐No **If yes, describe:**____________________

**10. Trauma History:**

Have you experienced any incidents of: a) Physical abuse? ☐ Yes ☐ No b) Sexual abuse? ☐ Yes ☐ No

If yes, are there things that remind you of the abuse and are difficult for you or cause you to act differently? If yes, describe: ____________________

Would you find it helpful to discuss these issues with staff? ☐Yes ☐No

Would you like more information on these issues in classes or support groups? ☐Yes ☐No

**11. Is there anything else you would like to tell me or discuss? If yes, describe:** ____________________

| **Date/Time** | **Individual's Signature** | **RN's Signature (Print and sign name)** |
|---|---|---|

**Additional Comments:** ***Use the space below to write additional information for any of the items on page 1. Specify which item number from the previous page you are responding to.***