De-Escalation Preferences Form for Aggressive Behavior

Note to therapist:

This form is for schools, outpatient clinics, or inpatient facilities that deal with people who have any type of escalation in aggressive behavior or severe symptoms of overwhelm or distress. This form will help you gather information to develop a de-escalation plan for your client. This is an important prevention tool that is individualized and trauma-informed to reduce difficult behaviors and possibly avoid restraint.

Use this form to identify strategies that are unique to your treatment environment and your client. You can either give this form to your client to fill out, or you can ask your client the questions and fill it in yourself.

Following clinical review, include this information in the client's behavioral contract or treatment plan.

De-Escalation Preferences

Name: _____ Date of Birth: _____

Date of completion: _____

It is helpful for me to know what can help you feel better when you are having a hard time. I might not be able to offer all these options, but I would like to work with you to identify how I can best support you.

What has worked for you? What helps you feel better? Check off the items that apply.

____ listening to music	____ playing a video game	____ going for a walk
____ using a weighted blanket or vest	____ calling a friend	____ getting a hug
____ punching a pillow	____ wrapping up in a blanket	____ watching TV
____ having your hand held	____ physical exercise	____ reading a book
____ voluntary time out	____ writing in your journal	____ pounding clay
____ breathing exercises	____ yoga/stretching	____ napping
____ lying down with a cold washcloth	____ talking to a loved one	____ cuddling a pet

____ putting your hands under running water

____ other: _____

____ other: _____

Is there a person who has been helpful to you when you are upset? Yes _____ No _____

If yes, who? _____

Do you give me permission to call and speak with this person? Yes _____ No _____

Phone: _____

If you agree I can call this person, please sign below.

Signature: _____

Date: _____

Witness: _____

Date: _____

What are some things that make it more difficult for you when you are upset? Are there triggers that cause you to escalate? Check off the items that apply.

____ being touched ____ being isolated ____ yelling

____ people in uniforms ____ loud noises ____ crowds

____ contact with person who is upsetting you ____ bright lights

____ being forced to do something ____ physical force ____ being threatened

____ time of day: when? _____ ____ having consequences

____specific scents – explain: _____

____ time of year – when? _____

____ feeling out of control – explain: _____

____ other: _____

____ other: _____

Do you have a history of trauma in childhood? This might include homelessness, natural disasters, an accident, or emotional, physical, or sexual abuse. Please explain.

_____

_____

_____

_____

_____

Have you ever been in a seclusion room? Yes _____ No _____

Have you ever been restrained? Yes _____ No _____

If yes, when? _____ Where? _____

Describe what happened.

_____

_____

_____

_____

_____

If you answered “yes,” have you ever discussed this with anyone? Yes _____ No _____

If not, is this an issue you would like to talk about? Yes _____ No _____

What helps you feel safe?

_____

_____

_____

_____

_____

Is there anything else you would like me to know?

_____

_____

_____

_____

_____