Trauma History Addendum

Data Field	Client Information
Person's Name (First, MI, Last)	Record first name, middle initial, and last name of the person served. Order of name is at agency discretion.
Record Number	Record agency's established identification number for the person.
Date of Admission	Record date the person served was admitted.
Organization/ Program Name	Record the organization and program for whom you are delivering the service.
DOB	Document date of birth of the person served.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.

Data Field	Trauma History Addendum (Describe in Comments Section Each Element Checked)
Traumatic Events list	For each traumatic event, describe specifics of trauma in the comments section to the right. Note if experience was single event or sustained over time. ***An example of Community Violence is gang violence**
Current Involvement by	Check the box(es) that apply. Add comments if necessary.
Additional Mandated Report Required?	In the person reports any activity that requires interviewer to report to an oversight agency, check the box(es) that apply. Add comments if necessary.

Data Field	Signatures
Person's Signature (Optional, if clinically appropriate)	The person served **should** be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a Progress Note and list the date here.
Date	Date of person's signature.
Parent/Guardian Signature	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives.
Date	Date of Parent/Guardian Signature.
Clinician/Provider – Print Name/Credential	**Legible** clinician/provider name and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor – Print Name/Credential (if needed)	If applicable, **legibly** record signature and credentials of supervisor.

Date	Date of this signature.
Clinician/Provider Signature	**Legible** signature, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor's Signature (if needed)	**Legible** signature and credentials of supervisor. **Example: Jerry Smith, LMHC**
Date	Date of this signature.
Physician/MD/DO Signature (if required)	**Legible** physician's signature if required by agency policy. Please note certain payers do require physician's signature. This is a requirement for Opiate Treatment Programs