

SUGGESTED SCREENING QUESTIONS

Produced by: The Family Violence Prevention Fund, 383 Rhode Island Street, Suite 304, San Francisco, CA 94103-5133, (415) 252-8900; October, 1999. Reprinted with permission by Priority Health, Grand Rapids, MI.

FRAMING QUESTIONS:

- Because violence is so common in many people's lives, I've begun to ask all my patients about it.
- I'm concerned that your symptoms may have been caused by someone hurting you.
- I don't know if this is a problem for you, but many of the woman I see as patients are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely.

Some of the lesbian women and gay men we see here are hurt by their partners. Does your partner ever try to hurt you?

DIRECT VERBAL QUESTIONS:

- Are you in a relationship with a person who physically hurts or threatens you?
- Did someone cause these injuries? Was it your partner/husband?
- Has your partner or ex-partner ever hit you or physically hurt you? Has he ever threatened to hurt you or someone close to you?
- Do you feel controlled or isolated by your partner?
- Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?
- Has your partner ever forced you to have sex when you didn't want to? Has your partner ever refused to practice safe sex?

FOR HISTORY INTAKE FORMS/NEW PATIENTS QUESTIONNAIRES:

Option 1:

➡ Have you ever been hurt or threatened by your boyfriend/husband/partner?

-OR-

➡ Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner?

-OR-

➡ Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner during this pregnancy?

-AND-

➡ Have you ever been raped or forced to engage in sexual activity against your will?

Option 2:

➡ Are you currently or have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid?

Option 3:

➡ Have you ever been forced or pressured to have sex when you did not want to?

➡ Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner?

FOR HISTORY INTAKE FORMS/NEW PATIENTS QUESTIONNAIRES:

Option 4:

Abuse Assessment Screen

1. Have you ever been emotionally or physically abused by your partner or someone important to you? YES NO

2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

If YES, by whom? _____ Total number of times: _____

3. Since you've been pregnant, were you hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

If YES, by whom? _____ Total number of times: _____

**Mark the area of injury on a body map.
Score each incident according to following the following scales:**

1 = Threats of abuse including use of a weapon

2 = Slapping, pushing, no injuries and/or lasting pain

3 = Punching, kicking, bruises, cuts and/or continuing pain

4 = Beating up, severe contusions, burns, broken bones

5 = Head injury, internal injury, permanent injury

6 = Use of weapon; wound from weapon

If any of the descriptions for the higher number apply, use the higher number.

4. Within the last year, has anyone forced you to have sexual activities? YES NO

If YES, by whom? _____ Total number of times: _____

5. Are you afraid of your partner or anyone you listed above? YES NO

Option 5

For use as a rubber stamp or printed Intake Form:

SCREENING: Yes No
 DV+ DV- DV?

or

SCREENING:
 DV+ DV- DV?

Note: "DV?" means that domestic violence is suspected.)

DOMESTIC VIOLENCE SCREENING/DOCUMENTATION FORM

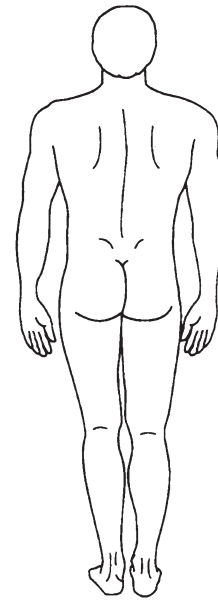
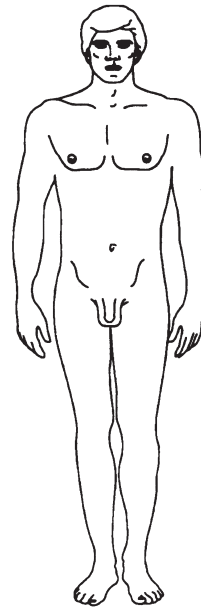
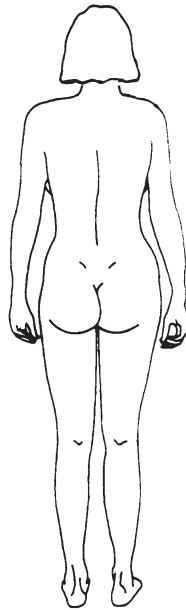
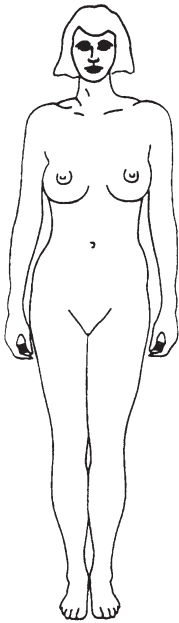
<p>DV Screen</p> <p><input type="checkbox"/> DV+ (Positive)</p> <p><input type="checkbox"/> DV? (Suspected)</p>
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Date _____ Patient ID# _____

Patient Name _____

Provider Name _____

Patient Pregnant? YES NO



Assess Patient Safety

- Yes No Is the abuser here now?
- Yes No Is the patient afraid of their partner?
- Yes No Is the patient afraid to go home?
- Yes No Has physical violence increased in severity?
- Yes No Has partner physically abused children?
- Yes No Have children witnessed violence in the home?
- Yes No Threats of homicide?
- By whom:
- Yes No Threats of suicide?
- By whom:
- Yes No History of mental illness?
- Yes No History of alcohol or substance abuse?
- Yes No Is there a gun in the home?
- Yes No Was safety plan discussed?

Referrals

- Yes No Hotline number given
- Yes No Legal referral made
- Yes No Shelter number given
- Yes No In-house referral made

Describe:

- Other referral made

Describe:

Reporting

- Law enforcement report made
- Child Protective Services report made
- Adult Protective Services report made

Photographs

- Yes No consent to be photographed?
- Yes No Photographs taken?

Attach photographs consent form

Developed by the Family Violence Prevention Fund and Educational Programs Associates, Inc.