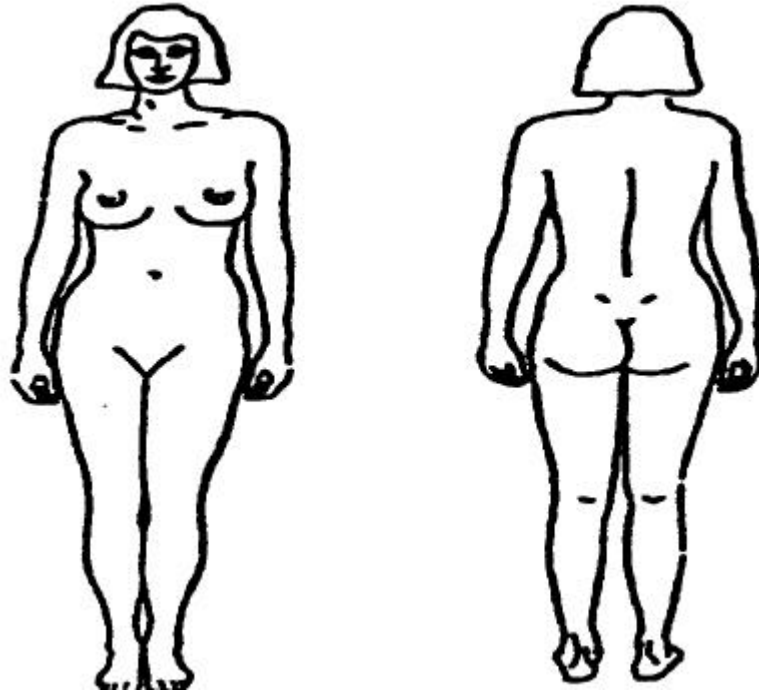


# DOMESTIC VIOLENCE



Date: \_\_\_\_\_ ID # \_\_\_\_\_  
 Time: \_\_\_\_\_ Patient DOB \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
 Provider Name: \_\_\_\_\_



## DANGER ASSESSMENT

Indicate on the drawing of the body above anywhere you have been hurt by your current partner.      Indicate any place a weapon has been used.

Several risk factors have been associated with homicides (murder) of both batterers and battered women/men through research which has been conducted after the killings have taken place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and to see how many of the risk factors apply to your situation. The s/he in the question refers to husband, wife, life partner, ex-husband, ex-wife, ex-partner, or whoever is physically hurting you.

Please check **YES** or **NO** for each question.

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 1. Is the abuser here now?  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 2. Are you afraid of your partner?  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 3. Are you afraid to go home?   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 4. Has the physical violence increased in frequency?  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 5. Has the physical violence increased in severity?   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 6. Does abuser ever try to choke you?   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 7. Threats of homicide?   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 8. Does abuser control daily activities (i.e. use of money, transportation, friends)?<br>If abuser tries, but you do not allow it, check here ____. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 9. Is abuser violently and constantly jealous of you (i.e. "If I can't have you, no one can")?  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 10. Alcohol or substance abuse?   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 11. Threats of suicide? By whom: _____  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 12. Is there a gun in the house?  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 13. Has your partner physically abused children?  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 14. Have your children witnessed violence in the home?  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 15. Have you discussed a safety plan with anyone?   |

