



Outreach Intake

WS File # _____ Advocate: _____

ALL INFORMATION IS CONFIDENTIAL

Date: _____ Time: _____ am pm

Name: _____ Age: _____ Date of Birth: _____ Gender :(M or F): _____

Marital Status (S/M/D/C): _____ Sexual Orientation: Bisexual Gay Heterosexual Lesbian Not Provided Other

Address: _____ City _____ State _____ Zip Code _____

Home Telephone :(____) _____ Cell Phone :(____) _____ is it safe to contact you at the phone number? **Yes No**

Are you of Hispanic Ethnicity? Yes No Middle Eastern Ethnicity? Yes No Haitian Ethnicity? Yes No

Race:
____ American Indian/Alaskan Native _____ Native Hawaiian/Other Pacific Islander
____ Asian _____ Unknown
____ Black/African American _____ Other
____ Multi-Racial _____ White

Emergency Contact person: _____ Phone #: _____

Do you have any disabilities? **YES NO** Do you need any special accommodations? _____

INCOME INFORMATION:

Yearly Household Income: \$ _____ Yearly Income WITHOUT Abuser: \$ _____

Number of Dependents: _____ Total Number of individuals in Household: _____

*******Domestic Violence Partner/Perpetrator Information *******

His/Her Name: _____ **Date of Birth** _____
Address: _____ City/State: _____ Zip: _____ County: _____
Telephone: (____) _____ Gender: Male Female
Race _____ Hispanic? Yes No Height _____ Weight _____ Hair Color _____ Eye Color _____

Acknowledgement

I hereby request counseling and/or advocacy for myself/my child(ren) from Abuse Counseling and Treatment, Inc. (ACT). I hereby release all ACT personnel/volunteers from any and all responsibilities for my action, decisions, and the well-being of myself/child(ren). *I understand that my records are protected by Federal and State confidentiality regulations and cannot be disclosed without my written consent. The exceptions to these regulations include incidents that could be deemed potentially life threatening, such as incidents of child abuse, suspected abuse of vulnerable adult, threats of suicide or homicide, or as required by law, i.e. by order of the court. Exceptions also include medical personnel in a medical emergency, receipt of a search warrant that specifies the individual or object of the search and alleges that the individual or object is located at the shelter, firefighting personnel in a fire emergency, any other person necessary to maintain the safety and health standards in the domestic violence shelter, and communication to law enforcement officers when the information is directly related to a client's commission of a crime or threat to commit a crime on the premises of a domestic violence shelter.*

I have been provided information on Florida Confidentiality and Privilege Laws, as well as policies and procedures of ACT regarding access to my file information, photos/videotapes and participation in public appearances. I was assessed for lethality and a Safety plan was developed with me. I received a copy of the Grievance procedure for ACT.

I, _____, acknowledge that the information collected during this Intake Assessment by Abuse Counseling & Treatment, Inc. has been reviewed by me and is correct to the best of my knowledge. Thank you for taking the time to complete this form. This information will help us to better meet your needs. Your cooperation is greatly appreciated.

Client Signature

Date

Counselor Signature

Date



Abuse and Lethality Assessment

Participant Name: _____

Date: _____

This abuse/lethality assessment is designed as a tool for survivors of domestic violence to use in evaluating/recognizing the abusive behaviors they have experienced, as well as the potential for harm or death in their relationship.

The word "lethal" means causing death. This "Lethality Assessment" is a tool to assess the possibility that a domestic violence victim may be killed. As you review these questions, consider that the more you have marked, the more dangerous the relationship may be.

BACKGROUND

1. How long have you been with your partner? _____
2. How long has your relationship been abusive? _____
3. When was the first incident of abuse? _____
4. When was the most recent incident of abuse? _____
5. Does it seem that the threats are occurring more frequently? YES or NO
6. Does it seem like the abuse is getting worse? YES or NO
7. Did your partner witness domestic violence as a child? YES or NO
8. Is your partner a survivor of child abuse? YES or NO
9. Is your partner a survivor of sexual assault? YES or NO

PET/ANIMAL ABUSE

1. As a child, did your partner witness the harming or killing of a pet or animal? YES or NO
2. Has your partner ever harmed, threatened to harm or killed a family pet or animal? YES or NO
3. Have you ever felt unable to leave your relationship out of fear for the safety of a pet?
YES or NO

PHYSICAL ABUSE (Check ALL that Apply):

Please check any physical abuse you have experienced with your partner:

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Hit | <input type="checkbox"/> cut | <input type="checkbox"/> burned |
| <input type="checkbox"/> kicked | <input type="checkbox"/> shot | <input type="checkbox"/> smothered |
| <input type="checkbox"/> thrown around | <input type="checkbox"/> pushed | <input type="checkbox"/> punched |
| <input type="checkbox"/> slapped | <input type="checkbox"/> choked | <input type="checkbox"/> restrained |
| <input type="checkbox"/> Spitting | <input type="checkbox"/> pulled hair | <input type="checkbox"/> thrown things |
| <input type="checkbox"/> Biting | <input type="checkbox"/> twisted arm | <input type="checkbox"/> Other: _____ |

How often is your partner physically violent? _____

Have you ever blacked out due to the abuse? YES or NO

Have you ever needed medical attention due to an abusive incident? YES or NO

Have you ever needed the police? YES or NO

Additional Information discussed: _____

EMOTIONAL (Check ALL that Apply):

Check any types of emotional abuse you have experienced with your partner:

- | | |
|--|--|
| <input type="checkbox"/> Forced acts you weren't comfortable doing | <input type="checkbox"/> made you feel crazy |
| <input type="checkbox"/> controlled your activities | <input type="checkbox"/> forced humiliating acts |
| <input type="checkbox"/> attacked your self –esteem | <input type="checkbox"/> abused you in front of others |
| <input type="checkbox"/> intentionally frightened you | <input type="checkbox"/> abused you in front of the children |
| <input type="checkbox"/> destroyed property | <input type="checkbox"/> screaming and yelling |
| <input type="checkbox"/> verbally abused you | <input type="checkbox"/> punching walls |
| <input type="checkbox"/> called you names | <input type="checkbox"/> Other: _____ |

How often does the emotional abuse occur? _____

Additional Information discussed: _____

PSYCHOLOGICAL (Check ALL that Apply):

Check any types of psychological abuse you have experienced with your partner:

Threatening Behavior:

- | | |
|--|--|
| <input type="checkbox"/> Destroy property | <input type="checkbox"/> injure family and friends |
| <input type="checkbox"/> Threatens deportation | <input type="checkbox"/> hurt you |
| <input type="checkbox"/> Displays weapons | <input type="checkbox"/> kill you |
| <input type="checkbox"/> take children away | <input type="checkbox"/> hurt himself |
| <input type="checkbox"/> harm the children | <input type="checkbox"/> kill himself |
| <input type="checkbox"/> kill the children | <input type="checkbox"/> harm a pet |

Has he followed through on any threats? YES or NO

If yes, describe _____

Additional Information discussed: _____

Isolation:

- | | |
|---|---|
| <input type="checkbox"/> Controls freedom to leave the home | <input type="checkbox"/> follows you around |
| <input type="checkbox"/> Isolates you from school, church, meetings | <input type="checkbox"/> questions your whereabouts |
| <input type="checkbox"/> Isolates you from friends or family | <input type="checkbox"/> Denies access to a car |
| <input type="checkbox"/> listens to phone calls | <input type="checkbox"/> Denies access to a telephone |
| <input type="checkbox"/> opens mail | <input type="checkbox"/> Denies access to a job |
| <input type="checkbox"/> monitors e-mail, text messages | <input type="checkbox"/> Controls finances |

How frequently are you psychologically abused? _____

Additional Information discussed: _____

SEXUAL ABUSE (Check ALL That Apply):

Have you ever been sexually abuse as a child or adult? YES or NO

If yes, age at first incident: _____

If exact age is unknown, please pick an age range at first incident:

- | | |
|--|--|
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Adult 2 (30-44) |
| <input type="checkbox"/> Child (0-12) | <input type="checkbox"/> Adult 3 (45-59) |
| <input type="checkbox"/> Teen (13-17) | <input type="checkbox"/> Adult 4 (60-64) |
| <input type="checkbox"/> Adult 1 (18-29) | <input type="checkbox"/> Adult 5 (65-99) |

Are you an adult survivor of incest? YES or NO

Has your partner ever:

- | | |
|---|---|
| <input type="checkbox"/> Forced you to have sex | <input type="checkbox"/> forced acts which felt uncomfortable |
| <input type="checkbox"/> tied you up against your will | <input type="checkbox"/> accused you of having affairs |
| <input type="checkbox"/> used objects against your will | <input type="checkbox"/> called you a whore or a slut |
| <input type="checkbox"/> attacked sexual body parts | <input type="checkbox"/> withholds sexual affection |
| <input type="checkbox"/> treated you like a sex object | <input type="checkbox"/> had affairs |

How frequently are you sexually abused? _____

Additional Information discussed: _____

LETHALITY

Please answer the following:

1. At this time do you feel your abuser knows where you are? YES or NO

Concerns: _____

2. Have you ever left your abuser before? YES or NO

If yes, how many times? _____

What behaviors/actions did he/she display? _____

3. At this time do you have concerns that your abuser may stalk you (if he knows your daily/weekly routine)? YES or NO

4. Has your partner ever threatened suicide? YES or NO

5. Has your partner ever threatened to kill you? YES or NO

6. Have you ever been afraid your partner would kill you? YES or NO

7. Do you believe your partner is capable of killing another person? YES or NO

8. Does your partner have weapons or access to weapons? YES or NO
9. Does your partner have fits of rage? YES or NO
10. Is your partner a jealous person? YES or NO
11. Does your partner appear obsessed with you? YES or NO
12. Does your partner use drugs or alcohol? YES or NO
13. Does the abuse escalate with substance abuse? YES or NO
14. How often are drugs or alcohol used? _____
15. Do you believe you can leave the house safely when the abuse begins to escalate? YES or NO
16. Has partner been violent with others? YES or NO
17. Has your partner ever been violent with law enforcement? YES or NO
18. Has your partner ever been arrested for domestic violence? YES or NO
If yes, how many times? _____
19. Is there a No Contact Order in place? YES or NO
20. Is there a warrant out on your partner because of domestic violence? YES or NO
If yes, where is the warrant from (City, County)? _____
21. Have you ever obtained an Injunction for Protection (IFP)/ restraining order? YES or NO
Do you feel you need an IFP now? YES or NO

Comments: _____

Thank you for completing the Abuse and Lethality Assessment. If you have any questions, please speak with your counselor.

Participant Signature

Date

Counselor Signature

Date

Outreach – Service Plan

This is the initial examination you and an outreach counselor will have in regards to goal setting. We understand that at this time you may be unaware of the goals you will need and want to set in the future. This is only a brief look at possible needs. As your time progresses here at the ACT, you and your counselor will develop more concrete service plans.

Are you employed: yes_____ no_____?

Monthly Income Level: Household: _____ Individual: _____

Goals

- | | |
|--|--|
| <input type="checkbox"/> Children’s needs | <input type="checkbox"/> Mental health care |
| <input type="checkbox"/> Dental care | <input type="checkbox"/> Probation/Parole Compliance |
| <input type="checkbox"/> Documentation | <input type="checkbox"/> Relocation |
| <input type="checkbox"/> Economic assistance | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Education | <input type="checkbox"/> Victim Services – Relocation |
| <input type="checkbox"/> Employment Income | <input type="checkbox"/> Victim Services – Victim’s Compensation |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Victim Services – Other |
| <input type="checkbox"/> Immigration | <input type="checkbox"/> Other |
| <input type="checkbox"/> Legal Assistance | |
| <input type="checkbox"/> Medical care | |

List any additional goals: _____

What would you like to achieve and/or learn through our services?

What challenges do you think you will face in achieving your goals?

Prioritize your goals:

List details (steps) on how you will achieve your stated goals:

Safety Plan: Discuss any goals related to the development/implementation of your safety plan:

Initial Referrals by staff:

Initial education provided:

VICTIM SERVICES:

Do you have a domestic violence arrest report within the past 30 days? Yes or No

Victim Services Programs (Office of the Attorney General)

Relocation Program explained to client

Victim Compensation Program explained to client

Address Confidentiality Program explained to client

Client requests to apply for a program offered through the Office of the Attorney General:

Yes or No

Pre-Qualification Guidelines for the Domestic Violence Relocation Program (Office of the Attorney General)

- Relocation program explained to client
- Client pre-qualifies for relocation
- Client does not meet pre-qualification guidelines
- Client requests Relocation Program services
- Client declines Relocation Program Services
- Not Applicable

Additional Information discussed: _____

Client Signature

Date

Counselor Signature

Date