



Catholic Social Services of Washtenaw County

Alternatives to Domestic Aggression

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Assessment & History

Individual Interview

Service Participant Name: _____ Age _____

DOB: ____/____/____

Service Participant's Appearance: Casual Formal Filthy

Date of Interview: ____/____/____

Interviewer Name: Cape Cook Garvin Knott _____

Are you on probation? Yes No

Who is your Probation Officer? _____

What is your reporting status? Intensive Monthly in Person Monthly in writing

Monthly on phone Non-Reporting Other: _____

Immediate attention:

Red Flag Area's

Any one of these "red flags" can stand on their own:

- The service participant is Court ordered to receive drug/alcohol treatment.
- The service participant was drunk at the time of the assault.
- The service participant thinks that he is an alcoholic.
- The service participant has a DUI charge/arrest/conviction (time frame: within the last 5 years. This would qualify this "red flag" to stand on it's own).
- The service participant has had more than one alcohol/drug arrest.
- The service participant has been in drug or alcohol treatment in the past and there is evidence of continued use or there is no involvement in a recovery program.
- The service participant has attended Alcoholics Anonymous (this may be correlated to #4).
- Outstanding information from the ADA self-questionnaire or the ADA assessment.
- Other: _____

1. Briefly describe the incident that brought you here. _____

2. What do you think caused you to do this? _____

3. What were you trying to accomplish? _____

4. What do you remember about being arrested? _____

5. Who called the police, and for what reason? _____

Family Systems Map

Include:

- Education,
- Cultural,
- Alcohol & Drug,
- Sexual Abuse, Physical Abuse,
- Employment,
- Current Location,
- Legal Status,
- Marital Status.
- Race

21. In what religion were you raised? _____

22. Do you belong to an organized religious group? Yes No Explain: _____

23. Are you satisfied with your current religious involvement? Yes No Explain: _____

24. Describe your contact with family. _____

25. Any changes in contact with family in the last year? Yes No Explain: _____

26. Do you spend time alone with your family? Yes No. Explain: _____

27. What was your family's response when they heard about the abuse? _____

28. Describe contact with friends in the last year. _____

29. Any changes in contact with friends in the last year? Yes No. Explain: _____

30. Do you spend time alone with your friends? Yes No. Explain: _____

31. What was your friends' response when they heard about the abuse? _____

32. What do you do for leisure with friends? _____

33. Relationship(s) History (List all intimate relationships) {Page 13} :

Violence in relationship? Sexual relationship? How did you meet? How did relationship end? Contact currently?	Ethnicity & Race Affairs Age met Use of AOD Employed Where what? Married/L TP/Children <i>Length of relationship</i>
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Additional information may be located on the reverse side of this page

34. What effects do you think your abuse has had on your children? (Page #12, 32-33)

No Children Denies any effect

35. Have you ever been denied visitation? Yes No Explain: _____

36. Have you ever missed/forgotten an obligation with your child? Yes No Explain: _____

37. Have there been any changes in living arrangements in the last year? Yes No

Explain: _____

38. Do you have any financial problems? Yes No Explain: _____

39. How is the money handled in your relationship? _____

40. Has there been any changes in your relationships and/or partners since the incident?

Yes No Explain: _____

41. Have you completed and signed a Information Release Authorization on your current partner? Yes No. N/A If no, please complete and sign release.

42. Does your partner spend time alone with her family? Yes No. Explain: _____

43. Does your partner spend time alone with her friends? Yes No. Explain: _____

44. What do you do for leisure with your partner and/or children? _____

45. Have you ever checked up on a partners whereabouts? Yes No.

Who & describe how: _____

46. What things do you generally argue with partners about? _____

47. Do you think your partner provokes you? Yes No

How does she do this? (page 12, #31) _____

48. Have you used prostitutes? # _____ Denies

Explanation (yes or no): _____

49. Tell me about the FIRST time you used violence against a woman (Page 10, #3, Page 11,

#22, Page 14, #13): The assault for which he was arrested see page #1

50. Tell me about the LAST time that you used violence against a woman:

The assault for which he was arrested see page #1

51. Tell me about the MOST VIOLENT time you used violence against a woman (page 12, #23): The assault for which he was arrested see page #1

52. What type of medical attention have any of your partners needed as a result of your abuse? Denies

53. Describe your most violent assault with another man: _____

54. LETHALITY ASSESSMENT INFORMATION: (circle one)

<p><i>Inform S.A.F.E. House immediately</i></p>	<p>Y N ?</p>	<p>Have you ever made threats of homicide or ever said "I can't live with out you?" If yes, explain:</p>
<p><i>Inform S.A.F.E. House immediately</i></p>	<p>Y N ?</p>	<p>Have you ever made threats of suicide, If yes to whom? (page 11, #11-12) <input type="checkbox"/> <i>Partner</i> <input type="checkbox"/> <i>Children</i> <input type="checkbox"/> <i>Other.</i> _____ If yes, explain:</p>
	<p>Y N ?</p> <p>Y N ?</p> <p>Y N ?</p>	<p>Do you own Weapons? include hunting rifles (page 15, #24): If you owned weapons, who has them now?</p> <p>Where are the weapons kept?</p> <p>Do you have access to the weapons? If yes, explain.</p> <p>Do you have access to any other weapons? If yes, explain.</p>

	<p>Y N ?</p> <p>Y N ?</p>	<p>Have you ever hurt a pet?</p> <p>Has your current or previous partner ever hurt a pet? (Page 16-17, Section 9, 33-39)</p> <p>If yes, explain:</p>
	<p>Y N ?</p>	<p>Drug/alcohol consumption (Also see Alcohol & Drug Use Assessment)</p>
<p><i>Inform S.A.F.E. House immediately</i></p>	<p>Y N ?</p>	<p>Has your current partner left you? When: With whom & where does your partner reside?</p> <p>When did your previous partner leave you: With whom & where does your previous partner reside:</p>
<p><i>Inform S.A.F.E. House immediately</i></p>	<p>Y N ?</p>	<p>Has your current partner said she is going to leave you? How come?</p> <p>How come your previous partner left you?</p>
<p><i>Inform S.A.F.E. House immediately</i></p>	<p>Y N ?</p>	<p>Do you suspect your current partner is going to leave? Why:</p>

	Y N ? NA	If you are separated/divorced from your most recent partner how do you arrange visits for the children?
	Y N ? NA	How do you arrange visits for children with previous partners?
	Y N ? NA	Do you have any question as to whether you are the father?
	Y N ? NA	Have you threatened to kidnap or get custody of the children? Describe:
	Y N ? NA	Are there "stepchildren" in your home?
	Y N ? NA	Have you ever assaulted your partner(s) while she was pregnant? Who and describe:
	Y N ? NA Y N ? NA	Is your partner pregnant? Do you have any question as to whether or not you are the father?
	Y N ?	Have you ever assaulted a partner in Public? Who and describe:

	Y N ?	Over time have your assaults increased in frequency? Describe:
	Y N ?	Have you ever assaulted her sexually? Describe:
	Y N ? NA	Have you threatened to get her deported?

Number of times police have ever been called or have come to the house for domestic violence:
(Page 4-6, Section 5)

_____ Times Called _____ Times Came Out

DOES NOT APPEAR TO BE A PROBLEM

55. DEPRESSION: (circle Y N ?)

Y N ? Sleep pattern change: increase/decrease	Y N ? Appetite increase/decrease
Y N ? Interests increase/decrease	Y N ? Psycho-motor agitation
Y N ? Guilt: increase/decrease	Y N ? Ever been diagnosed as depressed
Y N ? Energy increase/decrease	Y N ? Currently/ever take antidepressant medications . List name(s), dosage(s) & side effects:
Y N ? Concentration problems	Y N ? Any current Suicide thoughts/plans If yes, explain.

<p>Y N ? Ever been hospitalized.</p> <p>List date(s), hospital name(s) & reason(s):</p>	<p>Y N ? Do you think you are depressed?</p> <p>If yes, explain:</p>
<p>Y N ? Ever been in counseling.</p> <p>List date(s), agency(s) and reason(s):</p>	<p>Y N ? History of depression in family</p> <p>If yes, whom?</p>
<p>Y N ? Ever been diagnosed with any other mental health problem?</p> <p>If yes, explain including any prescribed medications:</p>	
<p><input type="checkbox"/> DOES NOT <u>APPEAR</u> TO BE A PROBLEM</p>	
<p>56. SUICIDE RISK: (circle Y N ?)</p>	
<p>Y N ? Feelings of hopelessness:</p>	<p>Y N ? Current suicide plans/thoughts. If yes, explain:</p>
<p>Y N ? Currently anhedonic:</p>	<p>Y N ? History of suicidal ideation/attempts. If yes, explain:</p>
<p>Y N ?: Currently psychotic:</p>	<p>Y N ? History of suicide or suicide attempts in family. If yes, explain:</p>
<p>Y N ?: Severe losses. If yes, describe:</p>	<p>Y N ? Chronic self-destructive lifestyle</p> <p>If yes, explain:</p>
<p>Y N ?: Upcoming anniversary:</p>	<p>Y N ? Conflicted over sexual orientation. If yes, explain:</p>
<p>Y N ? Inability to accept help</p>	<p>Y N ? Lack of rapport with interviewer:</p>

MEDICAL & PHYSICAL HEALTH INFORMATION:

57. What is the date and reason for your last doctor appointment: _____

58. What chronic illnesses do you have: None

<input type="checkbox"/> Diabetes:	<input type="checkbox"/> Migraines:
<input type="checkbox"/> Blood Pressure:	<input type="checkbox"/> Seizures:
<input type="checkbox"/> Arthritis:	<input type="checkbox"/> Lung Disease:
<input type="checkbox"/> Cardiac:	<input type="checkbox"/> Other:

59. Are you under a doctor's care for any illness? Yes No

Explain: _____

60. What prescription and over the counter drugs do you currently take? Denies

61. Have you ever had any injuries due to violence? Yes No _____

If yes, explain including date: _____

62. Have you ever been hospitalized or received emergency room treatment?

Yes No If yes, list date and reason: _____

63. Additional information (Pages 1-15): _____

Alcohol and Drug Use Assessment Section

1. SUBSTANCE USE CHART

	Age of first use	Age of first regular use	Maximum use qty/freq.	How much before feel effect	Current use	Last use	24 hours	48 hours
Alcohol								
Marijuana								
Amphetamines								
Sedatives								
Crack/Cocaine								
Hallucinogens								
Narcotics: Heroin Darvon Vicodin								
Inhalants								
Rx.								

2. Drug of Choice: _____

3. Where do you usually drink or use drugs? _____

4. With whom do you usually drink or use drugs? _____

SYMPTOMOLOGY

5. Has anyone ever said they were concerned about your AOD use? Who? What? _____

6. Have you ever used more or longer than intended? Yes No Explain: _____

7. Have you ever tried to limit or change the way you use AOD? Yes No. Explain: _____

8. Have you ever behaved in ways that would normally be unacceptable to you?

Yes No Explain: _____

9. Have you ever been violent when using AOD? Yes No Explain: _____

10. Have you engaged in risky, unprotected sex when using AOD? Yes No

Explain: _____

11. Have you ever been late, called in sick or been disciplined on a job because of AOD?

Yes No Explain: _____

12. Have you ever passed out from D/A use? Yes No Explain: _____

13. Have you ever had periods of time you couldn't account for or forgot (blacked out)?

Yes No Explain: _____

14. Have you ever had any physical symptoms before during or after use of AOD?

Yes No

Explain: _____

15. Do you ever drink to get drunk? Yes No Explain: _____

16. Have you ever had homicidal ideation/behavior while using AOD? Yes No

Explain: _____

17. Have you ever had suicidal ideation/behavior while using AOD? Yes No

Explain: _____

18. Have you ever driven after drinking/drunken? Yes No Explain: _____

19. Have you ever had legal issues related to AOD use? Yes No Explain: _____

20. Have you ever been arrested for an AOD offense? Yes No Explain: _____

21. Have you ever tried to stop using all AOD? Yes No

Explain: _____

22. Do you think you have a problem with alcohol or drugs? Yes No Explain: _____

23. MAST score (page 38-39): # _____

TREATMENT HISTORY

24. Have you ever had substance abuse treatment? Yes No If yes, please complete the following chart:

Date(s) of Program Attendance	Program Name	Level of Care	Length of Time in the Program	Completion of Program	Length of Time Clean	What Made You Go Back to AOD

25. Have you ever attended AA/NA? Yes No Explain (include frequency & type of meeting): _____

26. Did you have a sponsor? Yes No Explain: _____

27. Ever taken Antabuse? Yes No When? _____ Why? _____

28. Ever drink while on Antabuse? Yes No Results: _____

29. Any additional information you believe the ADA team needs to know? _____

ASSESSOR ONLY: This section is based on clinical impressions

30. Lethality Assessment Impression:

<p>Y N ? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></p>	<p>Fantasy of homicide</p>
<p>Y N ? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></p>	<p>Obsessiveness about partner or her family, friends</p>
<p>Y N ? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/> Y N ? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/> Y N ? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/> Y N ? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/> Y N ? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></p>	<p>Centrality of battered woman</p> <ul style="list-style-type: none">◆ Does current partner spend time alone with her friends? ◆ With her family of origin? ◆ Does service participant spend time alone with his friends? ◆ With his family origin?
<p>Y N ? <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></p>	<p>History of hostage/stalking behavior/abuse pattern</p>

Y N ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rage
Y N ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Acute mental health problems:
Y N ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ownership of partner

31. BATTERER "INTERACTION STYLE"

<input type="checkbox"/> Suspicious	<input type="checkbox"/> Jealous	<input type="checkbox"/> Alcoholic	<input type="checkbox"/> Distancing
<input type="checkbox"/> Dependent	<input type="checkbox"/> Aloof	<input type="checkbox"/> ACOA	<input type="checkbox"/> Isolated
<input type="checkbox"/> Borderline/Dysphoric	<input type="checkbox"/> Anxious attachment	<input type="checkbox"/> Dependent/Alcoholic	
<input type="checkbox"/> "Anti-Social"	<input type="checkbox"/> Fear of abandonment	<input type="checkbox"/> Emotionally abused as a child	
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	

32. BEHAVIOR AND TONE IN INTERVIEW

<input type="checkbox"/> <u>FEARFUL</u>	<input type="checkbox"/> <u>COOPERATIVE</u>	<input type="checkbox"/> <u>HONEYMOONING</u>	<input type="checkbox"/> <u>OPPOSITIONAL</u>	<input type="checkbox"/> <u>RIGHTEOUS</u>
<input type="checkbox"/> ashamed	<input type="checkbox"/> interested	<input type="checkbox"/> obsequious	<input type="checkbox"/> hostile	<input type="checkbox"/> grandiose
<input type="checkbox"/> guarded	<input type="checkbox"/> attentive	<input type="checkbox"/> ingenuous	<input type="checkbox"/> controlling	<input type="checkbox"/> dramatic
<input type="checkbox"/> sad	<input type="checkbox"/> pleasant	<input type="checkbox"/> flattering	<input type="checkbox"/> angry	<input type="checkbox"/> resentful
<input type="checkbox"/> depressed	<input type="checkbox"/> congenial	<input type="checkbox"/> manipulative	<input type="checkbox"/> antagonistic	<input type="checkbox"/> defensive
<input type="checkbox"/> guilty	<input type="checkbox"/> informative	<input type="checkbox"/> patronizing	<input type="checkbox"/> impatient	<input type="checkbox"/> imperious
<input type="checkbox"/> apprehensive	<input type="checkbox"/> thoughtful	<input type="checkbox"/> complimentary	<input type="checkbox"/> insulting	<input type="checkbox"/> self-centered
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. Focus of resistance: _____

34. Source of motivation: _____



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Service Participant Name:	Date of Birth:
Date of Interview:	
Interviewer Name: <input type="checkbox"/> Cape <input type="checkbox"/> Cook <input type="checkbox"/> Garvin <input type="checkbox"/> Knott <input type="checkbox"/> :	
Probation Officer: <input type="checkbox"/> NA	
<input type="checkbox"/> Corrello, <input type="checkbox"/> Henderson, <input type="checkbox"/> Lupi, <input type="checkbox"/> Mallory <input type="checkbox"/> :	

IMPRESSIONS AND/OR SUMMARY:

1. Abuse Incident(s):

	Low 1	2	3	4	High 5
2. Assessment of level of remorse: Rationale:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Childhood or Family of Origin:

4. Relationship(s):

5. Assault pattern and/or tactics:

6. Race, culture and ethnicity as relates to ADA service:

7. Mental Health:

8. Medical & Physical Health:

9. Substance Abuse:

No problem noted:

Substance Abuse of:

Based on recurrent substance use resulting in:

Failure to fulfill major role obligations at work, home or school

Situations which it is physically hazardous

Legal problems

Continued use despite having recurrent or persistent problems exacerbated by the effects of the substance

Substance Dependency of:

Based on a maladaptive pattern of substance abuse with:

Increased tolerance

Withdrawal symptoms

The substance often taken in larger amounts or longer period of time than intended

Great deal of time spent in activities necessary to obtain the substance

Persistent desire or unsuccessful efforts to cut down or control the substance

Substance use is continued despite negative effects

Important activities given up or decreased because of substance abuse

Alcohol / Drug treatment history Yes No NA, :

DUI charges/arrest/conviction history Yes No NA, Explain:

Recovery / relapse prevention plan Yes No NA, Explain:

10. LETHALITY RISK (as of the writing of this report):

TO CURRENT PARTNER: Name:

LOW LOW-MODERATE MODERATE MODERATE-HIGH HIGH

TO PREVIOUS PARTNER: Name:

LOW LOW-MODERATE MODERATE MODERATE-HIGH HIGH

TO SELF:

LOW LOW-MODERATE MODERATE MODERATE-HIGH HIGH

LETHALITY RATIONALE OF SERVICE PARTICIPANT TO:

CURRENT PARTNER	PREVIOUS PARTNER	SELF
Name:	Name:	
<input type="checkbox"/> Abused partner in public	<input type="checkbox"/> Abused partner in public	<input type="checkbox"/> Feelings of hopelessness
<input type="checkbox"/> Used weapon during abuse	<input type="checkbox"/> Used weapon during abuse	<input type="checkbox"/> Current or past psychotic symptoms
<input type="checkbox"/> Has access to weapons	<input type="checkbox"/> Has access to weapons	<input type="checkbox"/> Current anhedonic
<input type="checkbox"/> Believes partner provokes him	<input type="checkbox"/> Believes partner provoked him	<input type="checkbox"/> History of self harm act(s)
<input type="checkbox"/> Has stalked and/or checked on partner's whereabouts	<input type="checkbox"/> Has stalked and/or checked on previous partner's whereabouts	<input type="checkbox"/> History of suicidal ideation
<input type="checkbox"/> Have no close friends	<input type="checkbox"/> Has no close friends	<input type="checkbox"/> Current suicidal ideation
<input type="checkbox"/> Has made a threat of homicide	<input type="checkbox"/> Has made a threat of homicide	<input type="checkbox"/> Has a suicide plan of high lethality
<input type="checkbox"/> Has fantasy of homicide	<input type="checkbox"/> Has fantasy of homicide	<input type="checkbox"/> Has access to weapons
<input type="checkbox"/> Has said, "I can't live without you"	<input type="checkbox"/> Has said, "I can't live without you"	<input type="checkbox"/> Has accessibility to self-harm instrument to enact suicidal plan
<input type="checkbox"/> Continues to live with partner	<input type="checkbox"/> Previous partner lives alone/with children	<input type="checkbox"/> History of suicide in family of origin
<input type="checkbox"/> Separated from partner	<input type="checkbox"/> Previous partner has new partner	<input type="checkbox"/> History of suicide attempts in family of origin
<input type="checkbox"/> Partner lives alone/with children	<input type="checkbox"/> Has hurt a pet	<input type="checkbox"/> Made threats of suicide to partner to (current)/(previous) partner
<input type="checkbox"/> Partner has new partner	<input type="checkbox"/> Abuses alcohol and/or other drugs	<input type="checkbox"/> Made threats of suicide to children
<input type="checkbox"/> Has hurt a pet	<input type="checkbox"/> Has assaulted previous	<input type="checkbox"/> Current diagnosis of

CURRENT PARTNER	PREVIOUS PARTNER	SELF
Name:	Name:	
	partner while she was pregnant	depression
<input type="checkbox"/> Abuses alcohol and/or other drugs	<input type="checkbox"/> Questions as to whether he is the parent of un/born child	<input type="checkbox"/> Currently in therapy for depression
<input type="checkbox"/> Suspects partner is going to leave him	<input type="checkbox"/> Assaults have increased in frequency	<input type="checkbox"/> Currently on antidepressant medication
<input type="checkbox"/> Has assaulted partner while she was pregnant	<input type="checkbox"/> Had assaulted previous partner sexually	<input type="checkbox"/> History of diagnosis of depression
<input type="checkbox"/> Partner is pregnant	<input type="checkbox"/> Threatened to kidnap or get custody of the children	<input type="checkbox"/> History of in-patient treatment for depression
<input type="checkbox"/> Questions as to whether he is the parent of un/born child	<input type="checkbox"/> Has been denied visitation of his children	<input type="checkbox"/> History of out-patient therapy for depression
<input type="checkbox"/> Assaults have increased in frequency	<input type="checkbox"/> Has continued contact with "step-children"	<input type="checkbox"/> History of taking anti-depressant medication
<input type="checkbox"/> Has assaulted partner sexually	<input type="checkbox"/> Previous partner financially dependent on SP	<input type="checkbox"/> Believes he is depressed
<input type="checkbox"/> Threatened to kidnap or get custody of the children	<input type="checkbox"/> Previous partner lacks support system	<input type="checkbox"/> Past or current other major mental health disorder, with or without medication
<input type="checkbox"/> Has been denied visitation of his children	<input type="checkbox"/> Been violent as adolescent and/or child	<input type="checkbox"/> Suspects partner is going to leave him
<input type="checkbox"/> Has "step-children" in the home	<input type="checkbox"/> Been violent to male peers	<input type="checkbox"/> Partner has left him
<input type="checkbox"/> Partner financially dependent on SP	<input type="checkbox"/> Raised by a violent and/or abusive parent(s)	<input type="checkbox"/> Has no or limited support system
<input type="checkbox"/> Partner lacks support system	<input type="checkbox"/> Exhibits no remorse for past abusive behavior	<input type="checkbox"/> Experiencing severe losses
<input type="checkbox"/> Been violent as adolescent and/or child	<input type="checkbox"/> Obsessive about previous partner, family or friends	<input type="checkbox"/> Has stressful upcoming anniversary
<input type="checkbox"/> Been violent to male peers	<input type="checkbox"/> Previous partner initiated end of relationship	<input type="checkbox"/> Conflicted over sexual orientation
<input type="checkbox"/> Raised by a violent and/or abusive parent(s)	<input type="checkbox"/> Exhibits ownership of previous partner	<input type="checkbox"/> Has chronic self-destructive lifestyle
<input type="checkbox"/> Exhibits no remorse for past abusive behavior	<input type="checkbox"/> Acute medical health problem	<input type="checkbox"/> Abuses alcohol and/or drugs
<input type="checkbox"/> Obsessive about partner, family or friends	<input type="checkbox"/> History of stalking/hostage behavior	<input type="checkbox"/> History of abusing alcohol and/or drugs
<input type="checkbox"/> Exhibits ownership of partner	<input type="checkbox"/> Recent end of relationship	<input type="checkbox"/> Level of risk taking
<input type="checkbox"/> Acute medical health problem	<input type="checkbox"/> Has been abusive in front of the children and/or others	<input type="checkbox"/> Rage
<input type="checkbox"/> Long Term relationship	<input type="checkbox"/> Long Term relationship	<input type="checkbox"/> History of antisocial behavior
<input type="checkbox"/> Threatened Suicide	<input type="checkbox"/> Number of times the police	<input type="checkbox"/> Number of times the police

CURRENT PARTNER	PREVIOUS PARTNER	SELF
Name:	Name:	
	have been called for DV	have been called for DV:
<input type="checkbox"/> History of antisocial behavior	<input type="checkbox"/> Threatened Suicide	<input type="checkbox"/> Other:
<input type="checkbox"/> Has been abusive in front of the children and/or others	<input type="checkbox"/> History of antisocial behavior	<input type="checkbox"/> Other:
<input type="checkbox"/> Number of times the police have been called for DV:	<input type="checkbox"/> Rage	<input type="checkbox"/> Other:
<input type="checkbox"/> Level of risk taking	<input type="checkbox"/> Level of risk taking	<input type="checkbox"/> Other:
<input type="checkbox"/> Rage:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

11. Other outstanding information:

12. Clinical Impressions:

TREATMENT RECOMMENDATIONS

13. The following treatment recommended at this time:

- Continue and/or complete the ADA 52 Session Batterer Intervention Program:
- No Alcohol or Drug treatment indicated at this time:
- Referral to Dawn Farm program:
- Continue with the currently enrolled treatment or education program:
- Return to a drug/alcohol therapist, treatment or intervention program that he left:
- Obtain a psychological evaluation:
- Engage in individual psychotherapy:
- Obtain a psychiatric evaluation:
- Other:
- Removal of weapons from home:

Signature of Interviewer

_____/_____/_____
Date

Supervisor

_____/_____/_____
Date