Face Forward Inc.
Patient Intake Form / Assessment

MISSION

Face Forward's mission is to provide emotional support and reconstructive surgery for women, children and men who have been victims of Domestic Violence, Human Trafficking or any Cruel Acts of Crime.

Please help us by filling out the form below as completely and as honestly as possible. Your responses will be strictly confidential. **Please send 2 before and 2 after photos along with the form.**

Name (Last, First, M.I.):	**Sex:** ☐ **Male** ☐ **Female**	**DOB:**
Marital Status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**		
Social Security Number:	**Phone Number:**	
Address:	**Email Address:**	
Relationship to Abusive Partner:	**Are you still together?**	
How long have/had you been together?	**Have you ever left your abuser before?**	
Do you have health insurance?	**If yes, what type of insurance:**	
Have you ever been convicted of a crime?	**If yes, explain:** *Please note that this does not exclude you from possible services.	
Are you currently employed?	**If so, what type of work?**	
Are you currently in school/university?		

TRAFFICKING PATIENTS ONLY: PLEASE COMPLETE THIS SECTION:

From what ages were you a victim of trafficking? _____

Have you ever been directly/indirectly involved with a gang? If yes, explain.

_____

_____

*All Face Forward patients are subject to a drug test and background check.

What can Face Forward do for you? Tell us your story.

HEALTH HABITS AND PERSONAL SAFETY					
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes - pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Are you currently out of the abusive relationship?			☐ Yes	☐ No

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No
Have you ever been hospitalized or diagnosed with a mental illness?	☐ Yes	☐ No

ABUSIVE RELATIONSHIP / INCIDENTS

HERE IS A LIST OF BEHAVIORS THAT MANY SURVIVORS REPORT HAVE BEEN USED BY THEIR ABUSIVE PARTNERS OR FORMER PARTNERS. CHECK THOSE BEHAVIORS THAT YOUR PARTNER HAS USED AGAINST YOU. **Please indicate how many times your partner behaved in each of these ways during anytime you were together: Never, Once, Twice, 3-5 times, 6-10 times, 11-20times, more than 20 times; were your children in the house?**	**Never**	**Once**	**Twice**	**3-5 Times**	**6-10 Times**	**11-20 Times**	**More than 20 times**	**Were your children present? (Mark if yes)**
Called you names and/or criticized you	☐	☐	☐	☐	☐	☐	☐	☐
Gave you angry looks or stares	☐	☐	☐	☐	☐	☐	☐	☐
Prevented you from having money for your own use	☐	☐	☐	☐	☐	☐	☐	☐
Put down your family or friends	☐	☐	☐	☐	☐	☐	☐	☐
Tried to keep you from doing something you wanted to (i.e.: going out with family or friends, going to meetings or work or school)	☐	☐	☐	☐	☐	☐	☐	☐
Accused you of paying too much attention to someone or something else	☐	☐	☐	☐	☐	☐	☐	☐
Put you on an allowance	☐	☐	☐	☐	☐	☐	☐	☐
Used your children in any way to threaten you	☐	☐	☐	☐	☐	☐	☐	☐
Became very upset with you because dinner, housework, or laundry was not ready when he wanted it done or the way he thought it should be	☐	☐	☐	☐	☐	☐	☐	☐
Made you do something humiliating or degrading (example: begging for forgiveness, having to ask permission to use the car or do something)	☐	☐	☐	☐	☐	☐	☐	☐
Checked up on you (example: listened to your phone calls, checked the mileage on your car, called you repeatedly at work)	☐	☐	☐	☐	☐	☐	☐	☐
Threw, hit, kicked, or smashed something	☐	☐	☐	☐	☐	☐	☐	☐
Pushed, grabbed, shoved, choked or strangled you	☐	☐	☐	☐	☐	☐	☐	☐
Threatened to hit or throw something at you	☐	☐	☐	☐	☐	☐	☐	☐
Said things to scare you (i.e. Told you something bad would happen, threatened to commit suicide, kill you or take the children)	☐	☐	☐	☐	☐	☐	☐	☐
Slapped, hit kicked or punched you	☐	☐	☐	☐	☐	☐	☐	☐
Threatened you with a knife, gun or other weapon	☐	☐	☐	☐	☐	☐	☐	☐
Physically forced you to have sex/rape	☐	☐	☐	☐	☐	☐	☐	☐
Hurt you with a knife, gun or other weapon	☐	☐	☐	☐	☐	☐	☐	☐
Physically, emotionally or sexually abused the children	☐	☐	☐	☐	☐	☐	☐	☐
Describe any other abusive tactics your partner used								
Please explain your injuries								
Have you ever seen a physician for your injuries?	☐ Yes				☐ No			