



Patient Intake Form / Assessment

MISSION

Face Forward International'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:	DOB:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> 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.

A large, empty rectangular box with a thin black border, intended for the user to write their story. It occupies the majority of the page's vertical space.

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes - pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you currently out of the abusive relationship?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been hospitalized or diagnosed with a mental illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ABUSIVE RELATIONSHIP / INCIDENTS

<p>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.</p> <p>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?</p>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gave you angry looks or stares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prevented you from having money for your own use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Put down your family or friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accused you of paying too much attention to someone or something else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Put you on an allowance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used your children in any way to threaten you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Made you do something humiliating or degrading (example: begging for forgiveness, having to ask permission to use the car or do something)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Checked up on you (example: listened to your phone calls, checked the mileage on your car, called you repeatedly at work)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threw, hit, kicked, or smashed something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushed, grabbed, shoved, choked or strangled you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threatened to hit or throw something at you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Said things to scare you (i.e. Told you something bad would happen, threatened to commit suicide, kill you or take the children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slapped, hit kicked or punched you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threatened you with a knife, gun or other weapon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically forced you to have sex/rape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hurt you with a knife, gun or other weapon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically, emotionally or sexually abused the children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Describe any other abusive tactics your partner used								
Please explain your injuries								
Have you ever seen a physician for your injuries?	<input type="checkbox"/> Yes				<input type="checkbox"/> No			

