



PRE-INTAKE FORMS

ASSESSMENT PART 1

BEFORE YOU START

These pre-intake papers are not a sign of admission to the program. Please fill out all of the forms thoroughly and honestly.

TURN THESE PAPERS AND YOUR ADDITIONAL DOCUMENTS IN AT **400 E CENTRAL, SUITE 203**. YOU WILL BE CONTACTED TO SCHEDULE AN ASSESSMENT

For questions regarding the survey information, please call (580) 352-2047

DOCUMENTS TO SUBMIT WITH YOUR APPLICATION

- NOTICE OF CONFIDENTIALITY
- PARTICIPANT INFORMATION FORM
- IF APPLICABLE:**
- CRIMINAL RECORDS
 - Police Reports
 - Probable Cause Affidavits
 - Other Criminal History
- COURT RECORDS
 - Court order for BIP participation
 - Copies of active protective orders
 - Copies of Divorce Decrees and other related records
- DHS RECORDS
 - Current ISP or other plans
 - Drug & Alcohol Tests

All of these documents are important for us to understand your needs.
Please provide all of them as quickly as possible.

NOTICE OF FEES

- An intake and required assessments must be completed prior to attending the group sessions. The current fee for your assessment and intake is \$200.00. This fee is subject to change and due at time of intake whether you are accepted into the program or not.
- Participants will be required to pay at the beginning of each group. The fee for these meetings are: \$35.00 per group session for the 1st set of 13 weeks (1-13), \$25.00 per group for the 2nd set of 13 weeks (14-26), \$20.00 for the 3rd set of 13 weeks (27-39) and the last set of 13 weeks is FREE.
- If you cannot pay prior to group you will be allowed to attend group with the expectation that you will pay both group fees at the beginning of the subsequent group. If you do not pay the balance of group fees at the beginning of the subsequent group, you will be counted as absent.
- You are still required to complete 52 weekly groups to complete the program. All fees must be paid up to date.
- If you are discharged for excessive absences, non-compliance or reoffending, and the court or other referral source requests your reinstatement to group (within 3 months of termination), you will be expected to have all fees paid up to date, including a \$75.00 reinstatement fee, and comply with all rules and regulations of the program.
- If the reinstatement request is over 3 months after termination, a new intake and assessment will be conducted and a \$175.00 fee will be required.
- If you are discharged for non-compliance or reoffending, jail time may be recommended.
- If you are exited from STV, for any reason, no credit for prior program attendance will be allowed. Termination from the program terminates any and all credits accumulated by them per state statute.
- Payments types available are cash, money order, PayPal online, and PayPal Square for mobile.

Save time and pay online! Go to

https://www.survivorresourcenetwork.org/store/c2/BIP_Program.html#/
and use the PayPal option to take care of your assessment and group fees.

Money Orders can be made out to 'Survivor Resource Network'

NOTICE OF CONFIDENTIALITY

When services are provided at the Survivor Resource Network (SRN Inc.) all information is kept confidential (private) and cannot be released to anybody without your written permission. However, there are limited exceptions.

Your case may be discussed with other SRN Inc. counselors or supervisors for purposes of review and consultation, but all SRN Inc. personnel are bound by law and professional ethics to protect a client's confidentiality.

State law grants authority to the Office of Attorney General to collect information sufficient to meet its responsibilities related to oversight, management, evaluation, performance, improvement, and auditing of domestic violence and sexual assault in this state. However, any and all information reviewed or collected by the Attorney General shall be confidential and shall not be disclosed or used of any public purpose other than the creation of anonymous data for statistical reporting and analysis.

The Survivor Resource Network, Inc. is bound by state and federal laws to protect your confidentiality. Everything you reveal to us will be kept confidential with the exception of the following:

1. A staff or volunteer suspects physical or sexual abuse of a child.
2. If a staff or volunteer is concerned that the client is in serious danger of harming self or others.
3. If court ordered.
4. If you give permission to release information to a specific person or organization.

ADDITIONALLY, You are joining an educational program, not a therapeutic program and will not have the same level of confidentiality afforded by mental health services. The program will not assure confidentiality with respect to:

- Judge, District Attorney or referring agent
- Current partner
- Past or current victim(s) and/or a representative designated by the victim to receive information on behalf of the victim.
- Parent(s) or guardian(s) of any of your children
- Probation and parole
- Law enforcement
- Individuals toward whom there is a risk of imminent harm by you
- Coordinated Community Response Team
- The domestic violence victim services program serving the area where you may live or where the current or ex-partner lives, where guardians of your children live, or with the domestic violence program where you are currently residing
- Guardian Ad Litem

The program will promise confidentiality with respect to: the general public, news media and anyone else not covered in the expectations set forth above.

By signing, I state that I have read and understand my rights and limitations to confidentiality as outlined above. I also state that I agree to keep the names of other participants and staff confidential.

Client Signature

Date

Witness/Staff Signature

Date

"Please be advised any reasonable knowledge or suspicion of illegal activities or bodily harm, or a threat of such, to the victim, her or his property, or to third persons, or any attempt, threat or gesture to commit suicide, or any belief that child abuse or neglect is present or has occurred, will be reported to the appropriate person(s) or authorities."

Participant Initials: _____

PARTICIPANT INFORMATION

REFERRER INFORMATION

How did you hear about our Batterers Intervention Program?

- Self-Referred DHS Court Ordered by _____ County
 Other: _____

Have you or your partner(s) ever received services with the STV parent agency Survivor Resource Network, in the past? Yes No If yes, when? _____

CLIENT CONTACT & DEMOGRAPHIC INFORMATION

Name: _____ M.I. _____ Last: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone: (H) _____ (W) _____ (Cell) _____

Our agency does not discriminate on the basis of age, sexual orientation, gender identity, race, and income or language barriers. In order to ensure we consider the needs of all our guests, please consider answering the following questions:

Age: _____ **Date of Birth:** _____ **Are you a Veteran?** Yes No

Gender: Male Female Non – Binary: _____ Prefer not to disclose

Sexual Orientation: Straight/Heterosexual Gay or Lesbian Bisexual
 Prefer to self-describe _____ Prefer not to disclose

Preferred Pronouns: She/Her/Hers or He/Him/His T hey/Them/Theirs
 Ze / Hir Name Only

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

Ethnicity: Hispanic Non-Hispanic

Primary Language: _____ Translator Needed? Yes No

Marital Status:

Never Married Married Living as Married Divorced Widowed Separated

Employment:

Employment \$ _____ Full Time Part Time Employer: _____

NO FINANCIAL RESOURCES

Education:

Last Year Completed in School? _____ Degrees/Certifications? _____

Are you in School now? Yes No If yes, where? _____

EMERGENCY CONTACT	Name & Relationship: Address: Phone:
THIS CONTACT MAY NOT BE THE VICTIM OR ABUSED PARTNER	

ADULT PHYSICAL HEALTH HISTORY FORM

Food/Other Allergies: _____ Medication Allergies: _____

Are you Pregnant? Yes No NA If Yes, Due Date: _____ How many months? _____

Do you have a history of any of the following? *(Please check all that apply)*

- Not Applicable Seizures Heart Problems Stroke High Blood Pressure
- Asthma Diabetes Respiratory Problems Chemical Withdrawal
- Substance/Alcohol Abuse

Is there any pertinent medical information you would like for us to know? Yes No

If yes, please explain: _____

Is there anything preventing you from receiving medical care at this time? Yes No

If yes, please explain: _____

Current List of Medications/Dosage: _____

TRAUMATIC BRAIN INJURY

Have you ever been hit in the head? Yes No

Did you seek emergency room treatment? Yes No

Did you lose consciousness? Yes No

Are you having problems with concentration/memory? Yes No

Did you experience sickness or other physical problems following the injury? Yes No

ADULT MENTAL HEALTH HISTORY FORM

Have you ever received counseling for any reason?

Yes No Date(s) _____ Provider(s) _____

Have you ever been diagnosed with a mental health disorder or mental illness: Yes No

If yes, explain below.

	Diagnosis 1	Diagnosis 2	Diagnosis 3
Age when diagnosed: Where?			
Currently in treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been hospitalized for treatment of these diagnoses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you currently have any concerns about your own mental health? Yes No

If Yes, Explain: _____

Do you currently or have a history of experiencing auditory or visual hallucinations?

Yes No If Yes, Explain most recent occurrence: _____

Any current medications for mental health or mental illnesses? Yes No

Have you ever had suicidal thoughts/plans? Yes No

If Yes, what was the plan, when were the most recent thoughts, etc.:

SUBSTANCE / ALCOHOL USE HISTORY FORM

1. Do you think your current alcohol/drug use is excessive? Yes No

2. Have you ever received a chemical dependency or alcohol assessment? Yes No

3. Have you ever received chemical dependency or alcohol treatment? Yes No

If yes, did you complete treatment? Yes No _____

Please check any boxes that apply to you to complete the sentence. If the sentence is not true for you, mark "N/A" for Not Applicable. (Developed from the CAGE assessment)

I have felt the need to cut down on my use of...

- Alcohol Marijuana Cocaine Heroin
 Opioids Meth Tobacco Other N/A

I feel annoyed by people complaining about my use of...

- Alcohol Marijuana Cocaine Heroin
 Opioids Meth Tobacco Other N/A

I sometimes feel guilty about my use of...

- Alcohol Marijuana Cocaine Heroin
 Opioids Meth Tobacco Other N/A

I sometimes use this as an eye-opener in the morning or to relieve discomfort...

- Alcohol Marijuana Cocaine Heroin
 Opioids Meth Tobacco Other N/A

Describe your current alcohol/drug use

SUBSTANCE	AGE OF FIRST USE	LAST USE	FREQUENCY	METHOD	ANY CRIMINAL CHARGES?
ALCOHOL					
MARIJUANA					
COCAINE					
HEROIN					
OPIOIDS					
METH					
TOBACCO					
OTHER					

DHS HISTORY

Have you ever been involved in an investigation by:

- Department of Human Services (DHS)? Yes No
 - Date(s) _____
 - Currently involved
 - County _____
- Child Protective Services (CPS)? Yes No
 - Date(s) _____
 - Currently involved
 - County _____
- Adult Protective Services (APS)? Yes No
 - Date(s) _____

- Currently involved
- County _____

**** For Current Cases, please attach and review a copy of the Individualized Service Plan**

VICTIM INFORMATION

(This information should be for the most recent victim with whom you have been violent)

Name: _____ M.I. _____ Last: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone: (H) _____ (W) _____ (Cell) _____

How long have you been / were you in a relationship with the victim? _____

If victim is someone other than your current partner, what is the relationship to you?

If victim is not your current partner, what is the name of your current partner?

Current Partners Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone: (H) _____ (W) _____ (Cell) _____

Children:

How many children are you the biological parent of? _____

How many children does your partner have that you are NOT the biological parent of?

How many children do you have together, that you are BOTH the biological parents of?

How many children do you have in total, biological or non? _____

How many children currently live with you? _____

Minor Child's Name	DOB	Race/Gender	Grade	Age	Who has Custody?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

I am aware that all agents of Survivor Resource Network are mandated reporters for any disclosed and un-reported child abuse. I understand that if my facilitator contacts DHS they will discuss it prior to the referral and work closely with me during the process.

EFFECTS OF VIOLENCE ON CHILDREN

Have the children in your household ever seen you be violent? Yes No

If so, explain: _____

Have you ever been violent when you believed children in your household were sleeping?

Yes No If so, explain: _____

How do you think your violence might affect children in your household?

They tried to stop the violence Hiding or running away Copying violence

They are frightened by violence School difficulties Difficulties in other public areas

Other: _____

LAW ENFORCEMENT/COURT INVOLVEMENT

Have the police been called to your home because of a violent incident with a partner/spouse?

Yes No

If yes, how many times? _____ With whom? _____

Were you arrested for the most recent incident? Yes No

If yes, were you charged? _____

Have you been arrested in the past for violent crime Yes No

If yes, explain: _____

Are you on probation? Yes No

If yes, for how long and what are the terms of probation? _____

BIP Avoid victim Fines Abstain from alcohol/drugs

Substance evaluation No same or similar offenses Other: _____

Who is your probation officer? _____

Phone number: _____

Is there a protective order against you? Yes No

Date of order _____ Length of order _____

Judge _____ (CASE# PO- _____)

Conditions of protective order:

BIP CD Evaluation Where? _____

No contact No further abuse Excluded from residence

Contact only for visitation Use a visitation center Supervised visitation

Any other conditions? _____

What was your reaction to receiving a protective order against you?

ABUSE HISTORY INFORMATION

Have you ever received counseling for abusive behavior? Yes No

If so, when? _____ Where? _____ Duration? _____

When you were growing up, did you hear or witness violence? If yes, where?

Thinking about when you were a child, did you ever use violence against others? Yes No

In your family In your neighborhood On the street

School Sports Gangs Other? _____

Describe in detail the violent/abusive incident toward your partner that brought you to STV

BIP: _____

Describe in detail the worst violence you have committed:

Describe any violence you have used in previous relationships:

These are some behaviors that batterers admit to using in relationships – have you ever used any of the following:

Physical Abuse: (include how many times)

____ Slapped ____ Punched ____ Grabbed around the neck ____ Kicked ____ Choked

____ Pushed/Shoved ____ Torn their clothes ____ Spit at or pulled hair

____ Thrown something ____ Restrained the victim

Intimidation: (include how many times)

____ Frightened by looks, gestures, or actions ____ Screamed at ____ Smashed things

____ Destroyed their property ____ Displayed weapons

Has your victim ever been afraid of you? Yes No

Emotional Abuse: (include how many times)

- ___ Put them down ___ Called them names ___ Humiliated them
- ___ Made them feel guilty ___ Interrupted their sleeping or eating
- ___ Accused partner of flirting or cheating on you ___ Allowed others to abuse them

Isolation:

- ___ Kept them from going to places they choose – work, school, seeing family/friends
- ___ Opening their mail ___ Listened to their phone conversations
- ___ Followed them around ___ Questioned them about their whereabouts

Minimizing, denying, blaming:

- ___ Made light of abuse ___ Said it was their fault ___ Said it didn't happen
- ___ Blamed someone or something else

Using children:

- ___ Told children victim is not a good parent ___ Used visitation to harass victim
- ___ Threatened to take away the children
- ___ Used children to deliver messages

Male privilege:

- ___ Treated them like a servant ___ Acted like the "master of the castle"
- ___ Not shared children ___ Told her what her job/role is
- ___ Not done fair share of housework ___ Bossed her around

Economic Abuse:

- ___ Prevented them from working outside the home ___ Made them ask for money
- ___ Withheld information about the family income ___ Not paid child support
- ___ Kept the check book from them
- ___ Made major financial decisions without their input

Coercion and threats:

- ___ Threatened to harm them ___ Made them do something illegal
- ___ Tried to get her to drop charges and/or protective order
- ___ Threatened to harm their family and/or friends

Sexual Abuse:

- ___ Sex with them while they were sleeping or unconscious ___ Rape
- ___ Berate them for their sexual history ___ Molestation ___ Incest
- ___ Insist on certain acts that the partner doesn't like (oral, anal, etc.)
- ___ Insist on certain clothing or prevent certain clothing ___ Have affairs
- ___ Make fun of their body and body parts ___ Call names like slut or whore
- ___ Insist on touching them when they don't want that

When was the last incident of any kind of abuse toward your partner? _____

Describe: _____

Have you used violence against other people? Yes No

If so, describe: _____

Has your partner ever tried to get outside help because of the abuse? (e.g., police, sheltering, counseling) Yes No

Explain: _____

Has your partner ever received medical treatment as a result of violence? Yes No

If so, explain: _____

Have you ever killed or injured a pet? Yes No

If so, explain: _____

Have you ever used pornography? Yes No

Have you ever pressured your partner to watch pornography? Yes No

Try to remember how often you: (indicate by labeling Never-Rarely-Sometimes-Often-Always)

	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
Discuss issues relatively calmly					
Listen to your partner					
Apologize to your partner					
Ask for your partners opinion					
Talk through disagreements					
Support partners decision to do something for themselves					
Leave the room to calm down when you feel yourself getting upset					

BOAT INVENTORY ON ANIMAL RELATED ABUSE

1. Have you ever deliberately hurt, tortured, or killed a pet or animal in a cruel way?

Yes No

a. How old were you? _____

b. Were you alone? Yes No

c. What happened afterwards?

2. Have you ever given animals any drugs? Yes No

3. Have you ever made animals fight? Yes No

4. Have you ever done mean things or threatened to do mean things to animals trying to control another person? Yes No

LETHALITY RISK FACTORS

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have you ever used a weapon against them or threatened them with a lethal weapon?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Do you own a gun?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Have you threatened to kill them?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Have you ever threatened to harm or kill their children?
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Do you believe you are capable of killing them?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Do you believe the victim thinks you will try to kill them?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Do you ever try to choke them?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Are you violently and constantly jealous of them?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Do you control most or all of their daily activities?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Have they ever left or separated from you after living together or being married?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Are you unemployed?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Have you ever threatened or tried to commit suicide?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Does the victim have a child that you know is not yours?
<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Do you follow or spy on them, leave threatening notes or messages or answering machines, destroy their property, or call when they don't want you to?
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Have you avoided being arrested for domestic violence?
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Have you ever forced them to have sex when they did not wish to do so?
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Are you an alcoholic or problem drinker?
<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Have you ever beaten them while she was pregnant?

In the past six months, has your relationship:

- Become more violent Stayed about the same level of violence
 Become less violent

Have you decided to stop using violence in the past? Yes No

What are some things you have done to avoid using violence? _____

What might happen if you **don't** stop using violence?

Short-term:

Long-term:

What positive changes would you like to make for yourself? _____

The next part of the BIP application process is a face-to-face domestic abuse assessment conducted by a Survivor Resource Network BIP employee. The computerized report generated by the assessment software will, along with the information you have provided on this form, be used to determine if you will be accepted into the program. SRN is required by law to provide the referring court with a letter containing a brief summary of the assessment findings and whether or not you have been accepted. Your signature below indicates your understanding of this requirement and authorizes SRN to provide the necessary letter to the court that referred you here.

Additionally, I have read and understand all of the contents and have signed my name freely, voluntarily and without coercion. I attest that all of the information provided is factual.

Participant Signature

Date

Staff Signature

Date

Additional Recommendations (Staff use only):

**** For Office Use Only ****

WITHIN SEVEN DAYS OF FINAL ASSESSMENT:

- ADMISSION REPORT SENT TO COURT/REFERRING AGENCY
- REJECTION REPORT SENT TO COURT/REFERRING AGENCY
- INITIAL VICTIM/PARTNER CONTACT MADE