



## Woman Abuse Screening Checklist

I ask every woman about a history of abuse, because so often women experience physical, sexual, or emotional abuse as children, adolescents or as adults. All staff here are beginning to realize the serious life long effects abuse can have on women and their children, and want to help families break the cycle of abuse.

**YES NO**

- |                          |                          |   |                                    |                                    |
|--------------------------|--------------------------|---|------------------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Experienced abuse in the last 12 months?                    | <input type="checkbox"/> sexual    | <input type="checkbox"/> physical  |
|                          |                          |   | <input type="checkbox"/> emotional | <input type="checkbox"/> financial |
| <br>                     | <br>                     | <br>  | <br>                               | <br>                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Experiencing abuse now?                                     | <input type="checkbox"/> sexual    | <input type="checkbox"/> physical  |
|                          |                          |   | <input type="checkbox"/> emotional | <input type="checkbox"/> financial |
| <br>                     | <br>                     | <br>  | <br>                               | <br>                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Experienced abuse in the past?                              | <input type="checkbox"/> sexual    | <input type="checkbox"/> physical  |
|                          |                          |   | <input type="checkbox"/> emotional | <input type="checkbox"/> financial |
|                          | <input type="checkbox"/> | Answers <b>NO, but indicators present (go to #3)</b>        |                                    |                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you still have contact with abuser? _____                |                                    |                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you feel safe now? _____                                 |                                    |                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Do children in your home witness or experience abuse? _____ |                                    |                                    |

**2. If Client answered YES to any of the above, complete the following:**

**Done**

- Document in record
- Give referral tear-off sheet
- Assess safety
- Provide safety plan

**Referrals Made During Visit**

- Women's Helpline
- Short-term care/housing/shelter
- Emergency sexual assault care
- Police
- Children's Aid Society
- Counseling/group

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**3. If the client reports NO abuse, but indicators are present, continue with following interventions:**

**Done**

- Discuss specific indicators that cause you to suspect abuse
- Provide general information about women abuse and negative health effects
- Document responses and any suspect indicators (see other side)
- Provide referral tear off sheet.

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