

Safety Inventory

Name: _____

This information is used to assist with safety planning.

Monitoring/Control

Yes No

- Does your partner try to control your daily activities?
- Does your partner go through your personal belongings?
- Is your partner controlling or violent outside the home?
- Does your partner listen in or to your phone calls or tapped the phones?
- Does your partner read and/or track your mail?
- Does your partner monitor your email or internet use?
- Does your partner ask you to check in constantly regarding your activities/whereabouts?
- Does your partner ask your children to report on your activities and/or whereabouts?
- Has your partner ever appeared unexpectedly someplace where you were?
- Does your partner watching/follow/stalk you?
- Does your partner have another person watching you?
 - Friend
 - Family Member
 - Paid stranger or Professional Detective

Threats/Control

Yes No

- Has the abuse been escalating/getting worse?
- Does your partner try to intimidate you?
- Does your partner tell/threaten you that he/she will never let you go?
- Does your partner have access to a weapon?
List the weapons you think your partner has or has access to: _____
Where are the weapons currently located? _____
- Do you have access to a gun/weapon?
- Has your partner threatened you with a weapon?
- Has your partner ever threatened to take the children?
- Has your partner ever taken your children without your permission?
- Has your partner prevented you from taking the children with you when you have attempted to flee?
- Has your partner threatened to kill/harm you?
- Has your partner ever driven recklessly or caused an accident with you in the car?
- Has your partner ever threatened or harmed a pet?
- Do you believe your partner is capable of killing you?
- Do you feel this won't end until one of you is dead?

Chemical Use

What types of drugs and/or alcohol does your partner use? _____

Yes No

Is your partner taking medications? If so, what kind? _____

Has your partner been violent while using alcohol and/or drugs?

Has your partner forced you to use drugs/or alcohol?

What type of alcohol and/or drugs do you currently use? _____

Are you currently using any prescriptions? If yes, what kind? _____

Has your use changed recently? If yes, how so? _____

While under the influence have you found yourself in jeopardy?

Was it recently? Yes No

Have you ever felt that you needed to use prescriptions, alcohol, or drugs to cope?

Have you ever received treatment for drug/alcohol problems?

Partner's History

Yes No

Has your partner ever been convicted of a crime?

If so, what crime: _____

Is your partner on probation? If yes, Misdemeanor or Felony

Does your partner have any mental health issues and/or is he/she receiving treatment?

Has your partner ever attended domestic violence treatment?

If yes, circle one: Currently involved with a program Attended in the past

Which program? _____

Does your partner know you are seeking/using any of the following services?

If yes, please check the services he/she is aware of you accessing.

- EDVP Crisis Line Divorce
- Counseling Shelter
- Order of Protection

Please fill out this section in case of an emergency.

Partner's Name: _____ Nickname/Alias: _____

Gender: Male Female

Race: American Indian/Alaskan Native Arab/Middle Eastern Caucasian
 Asian Black/African American Hispanic/Latino
 Pacific Islander Mixed Race: _____

Date of Birth: ____/____/____ Height: _____ Weight: _____

Eye Color: _____ Glasses? Yes No Hair Color: _____

Current Address of partner: _____

Name/Address of Employer: _____ City Zip Code
 Work Hours: _____

City Zip Code

Vehicle Yr./Make/Model: _____

Vehicle Color: _____ Vehicle License: _____

Places your partner frequents:
