

NON-FATAL STRANGULATION DOCUMENTATION FORM

Patient Name: _____

Date: _____

Medical Record Number: _____

Time: _____

Strangulation is a serious event that often occurs in the context of intimate partner violence (IPV). Many times strangulation presents **NO VISIBLE INJURIES**. It is important to ask about strangulation in all IPV cases, and document positive disclosure or any signs and symptoms.

Strangulation Event History

How long did the strangulation last? _____ seconds _____ minutes _____ cannot recall

How many times did strangulation occur? _____

Why/how did the strangulation stop? _____

What type of strangulation occurred? (Check all that apply)

Hanging Ligature Manual Other

What was used to strangle the patient?

Right hand Left hand Both hands Unknown Chokehold maneuver

Other (describe) _____

Was the patient smothered?

No Yes (describe) _____

Was the patient shaken during the incident?

No Yes (describe) _____

Was the patient's head pounded against any object during the incident?

No Yes (describe) _____

Was the patient slapped, kicked, or bitten anywhere?

No Yes (describe) _____

Was the assailant wearing any jewelry on hands or wrists?

Unknown No Yes (describe) _____

Describe the neck pressure during strangulation on a 0-10 scale (0=no pressure and 10=crushing pressure):

What is the measurement of the patient's neck circumference? _____

Was the patient sexually assaulted?

No Yes

What was the patient thinking during the strangulation?

What did the assailant say before, during, or after the strangulation?

Describe mannequin demonstration (where applicable)

Signs/Symptoms of Strangulation

The following signs/symptoms should be asked about, assessed for and documented in writing, with body mapping, and by photo-imaging (if applicable). **Check ALL that apply.**

Signs	Prior to Strangulation	During Strangulation	After Strangulation	At time of Assessment
Face	<input type="checkbox"/> Red, flushed <input type="checkbox"/> Petechiae <input type="checkbox"/> Abrasions <input type="checkbox"/> Cuts <input type="checkbox"/> Lacerations <input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Other _____	<input type="checkbox"/> Red, flushed <input type="checkbox"/> Petechiae <input type="checkbox"/> Abrasions <input type="checkbox"/> Cuts <input type="checkbox"/> Lacerations <input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Other _____	<input type="checkbox"/> Red, flushed <input type="checkbox"/> Petechiae <input type="checkbox"/> Abrasions <input type="checkbox"/> Cuts <input type="checkbox"/> Lacerations <input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Other _____	<input type="checkbox"/> Red, flushed <input type="checkbox"/> Petechiae <input type="checkbox"/> Abrasions <input type="checkbox"/> Cuts <input type="checkbox"/> Lacerations <input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Other _____
Eyes	<input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae: Conjunctiva <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> Eyelids <input type="checkbox"/> <i>Upper right</i> <input type="checkbox"/> <i>Lower right</i> <input type="checkbox"/> <i>Upper left</i> <input type="checkbox"/> <i>Lower left</i> <input type="checkbox"/> Subconjunctival hemorrhage <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Ptosis <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Vascular congestion <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Other _____	<input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae: Conjunctiva <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> Eyelids <input type="checkbox"/> <i>Upper right</i> <input type="checkbox"/> <i>Lower right</i> <input type="checkbox"/> <i>Upper left</i> <input type="checkbox"/> <i>Lower left</i> <input type="checkbox"/> Subconjunctival hemorrhage <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Ptosis <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Vascular congestion <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Other _____	<input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae: Conjunctiva <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> Eyelids <input type="checkbox"/> <i>Upper right</i> <input type="checkbox"/> <i>Lower right</i> <input type="checkbox"/> <i>Upper left</i> <input type="checkbox"/> <i>Lower left</i> <input type="checkbox"/> Subconjunctival hemorrhage <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Ptosis <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Vascular congestion <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Other _____	<input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae: Conjunctiva <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> Eyelids <input type="checkbox"/> <i>Upper right</i> <input type="checkbox"/> <i>Lower right</i> <input type="checkbox"/> <i>Upper left</i> <input type="checkbox"/> <i>Lower left</i> <input type="checkbox"/> Subconjunctival hemorrhage <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Ptosis <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Vascular congestion <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Other _____
Nose	<input type="checkbox"/> Bleeding <input type="checkbox"/> Swelling <input type="checkbox"/> Petechiae <input type="checkbox"/> Discoloration <input type="checkbox"/> Other _____	<input type="checkbox"/> Bleeding <input type="checkbox"/> Swelling <input type="checkbox"/> Petechiae <input type="checkbox"/> Discoloration <input type="checkbox"/> Other _____	<input type="checkbox"/> Bleeding <input type="checkbox"/> Swelling <input type="checkbox"/> Petechiae <input type="checkbox"/> Discoloration <input type="checkbox"/> Other _____	<input type="checkbox"/> Bleeding <input type="checkbox"/> Swelling <input type="checkbox"/> Petechiae <input type="checkbox"/> Discoloration <input type="checkbox"/> Other _____

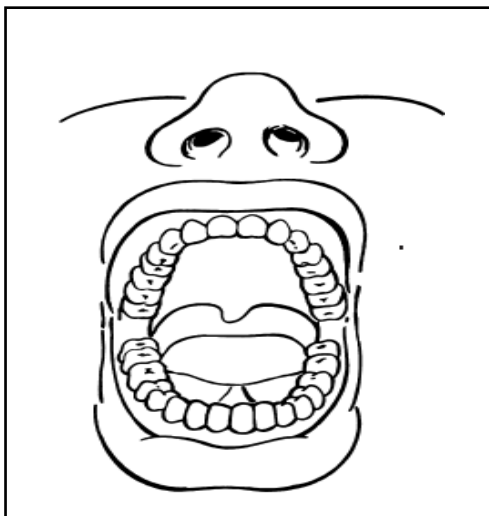
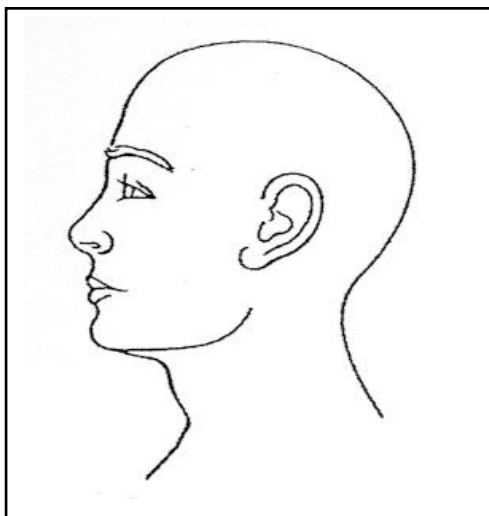
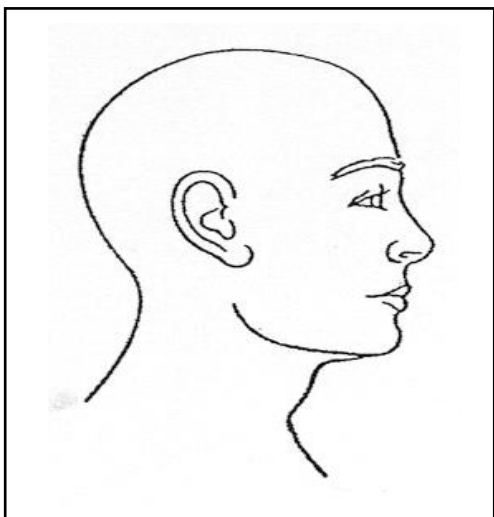
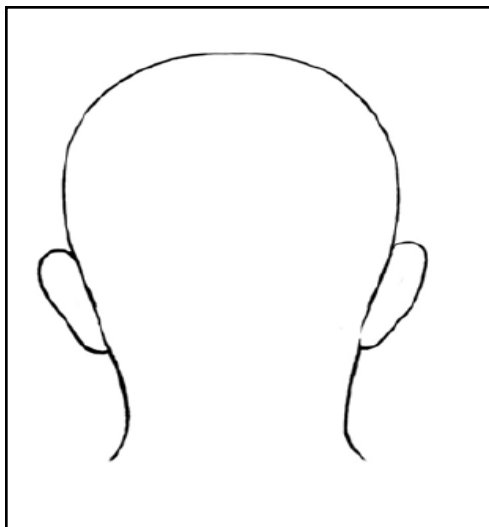
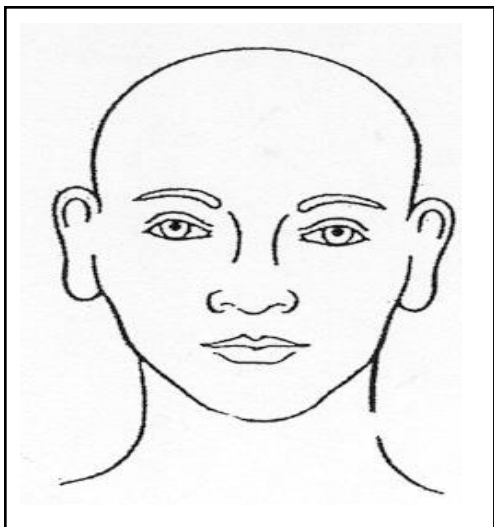
Signs	Prior to Strangulation	During Strangulation	After Strangulation	At time of Assessment
Mouth	<input type="checkbox"/> Discoloration <input type="checkbox"/> Swollen tongue <input type="checkbox"/> Swollen lips <input type="checkbox"/> Cut <input type="checkbox"/> Lacerations <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae <input type="checkbox"/> Other	<input type="checkbox"/> Discoloration <input type="checkbox"/> Swollen tongue <input type="checkbox"/> Swollen lips <input type="checkbox"/> Cut <input type="checkbox"/> Lacerations <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae <input type="checkbox"/> Other	<input type="checkbox"/> Discoloration <input type="checkbox"/> Swollen tongue <input type="checkbox"/> Swollen lips <input type="checkbox"/> Cut <input type="checkbox"/> Lacerations <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae <input type="checkbox"/> Other	<input type="checkbox"/> Discoloration <input type="checkbox"/> Swollen tongue <input type="checkbox"/> Swollen lips <input type="checkbox"/> Cut <input type="checkbox"/> Lacerations <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae <input type="checkbox"/> Other
Ears	<input type="checkbox"/> Petechiae <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Bleeding from ear canal <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Discoloration <input type="checkbox"/> Auditory changes <input type="checkbox"/> Other	<input type="checkbox"/> Petechiae <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Bleeding from ear canal <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Discoloration <input type="checkbox"/> Auditory changes <input type="checkbox"/> Other	<input type="checkbox"/> Petechiae <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Bleeding from ear canal <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Discoloration <input type="checkbox"/> Auditory changes <input type="checkbox"/> Other	<input type="checkbox"/> Petechiae <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Bleeding from ear canal <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Discoloration <input type="checkbox"/> Auditory changes <input type="checkbox"/> Other
Head/scalp	<input type="checkbox"/> Petechiae on scalp <input type="checkbox"/> Pulled hair <input type="checkbox"/> Contusions <input type="checkbox"/> Other	<input type="checkbox"/> Petechiae on scalp <input type="checkbox"/> Pulled hair <input type="checkbox"/> Contusions <input type="checkbox"/> Other	<input type="checkbox"/> Petechiae on scalp <input type="checkbox"/> Pulled hair <input type="checkbox"/> Contusions <input type="checkbox"/> Other	<input type="checkbox"/> Petechiae on scalp <input type="checkbox"/> Pulled hair <input type="checkbox"/> Contusions <input type="checkbox"/> Other
Neck/under Chin	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Ligature marks <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Ligature marks <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Ligature marks <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Ligature marks <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other
Shoulders	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Other	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Other	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Other	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Other

Signs	Prior to Strangulation	During Strangulation	After Strangulation	At time of Assessment
Chest	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other _____	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other _____	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other _____	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other _____

Symptoms	Prior to Strangulation	During Strangulation	After Strangulation	At time of Assessment
Behavioral	<input type="checkbox"/> Agitation <input type="checkbox"/> Combative <input type="checkbox"/> Anxiety <input type="checkbox"/> Memory disruption <input type="checkbox"/> Confusion <input type="checkbox"/> Other _____	<input type="checkbox"/> Agitation <input type="checkbox"/> Combative <input type="checkbox"/> Anxiety <input type="checkbox"/> Memory disruption <input type="checkbox"/> Confusion <input type="checkbox"/> Other _____	<input type="checkbox"/> Agitation <input type="checkbox"/> Combative <input type="checkbox"/> Anxiety <input type="checkbox"/> Memory disruption <input type="checkbox"/> Confusion <input type="checkbox"/> Other _____	<input type="checkbox"/> Agitation <input type="checkbox"/> Combative <input type="checkbox"/> Anxiety <input type="checkbox"/> Memory disruption <input type="checkbox"/> Confusion <input type="checkbox"/> Other _____
Neurological	<input type="checkbox"/> LOC <input type="checkbox"/> Uncertain if LOC <input type="checkbox"/> Incontinence of urine <input type="checkbox"/> Incontinence of feces <input type="checkbox"/> Seizures <input type="checkbox"/> Headache _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Dizzy <input type="checkbox"/> Fainting <input type="checkbox"/> Tinnitus <input type="checkbox"/> Visual changes <input type="checkbox"/> Other _____	<input type="checkbox"/> LOC <input type="checkbox"/> Uncertain if LOC <input type="checkbox"/> Incontinence of urine <input type="checkbox"/> Incontinence of feces <input type="checkbox"/> Seizures <input type="checkbox"/> Headache _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Dizzy <input type="checkbox"/> Fainting <input type="checkbox"/> Tinnitus <input type="checkbox"/> Visual changes <input type="checkbox"/> Other _____	<input type="checkbox"/> LOC <input type="checkbox"/> Uncertain if LOC <input type="checkbox"/> Incontinence of urine <input type="checkbox"/> Incontinence of feces <input type="checkbox"/> Seizures <input type="checkbox"/> Headache _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Dizzy <input type="checkbox"/> Fainting <input type="checkbox"/> Tinnitus <input type="checkbox"/> Visual changes <input type="checkbox"/> Other _____	<input type="checkbox"/> LOC <input type="checkbox"/> Uncertain if LOC <input type="checkbox"/> Incontinence of urine <input type="checkbox"/> Incontinence of feces <input type="checkbox"/> Seizures <input type="checkbox"/> Headache _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Dizzy <input type="checkbox"/> Fainting <input type="checkbox"/> Tinnitus <input type="checkbox"/> Visual changes <input type="checkbox"/> Other _____
Throat/Voice	<input type="checkbox"/> Dysphagia <input type="checkbox"/> Odynophagia (pain) <input type="checkbox"/> Dysphasia <input type="checkbox"/> Aphasia <input type="checkbox"/> Drooling or Inability to swallow <input type="checkbox"/> Throat pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Hoarse/Raspy <input type="checkbox"/> Other _____	<input type="checkbox"/> Dysphagia <input type="checkbox"/> Odynophagia (pain) <input type="checkbox"/> Dysphasia <input type="checkbox"/> Aphasia <input type="checkbox"/> Drooling or Inability to swallow <input type="checkbox"/> Throat pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Hoarse/Raspy <input type="checkbox"/> Other _____	<input type="checkbox"/> Dysphagia <input type="checkbox"/> Odynophagia (pain) <input type="checkbox"/> Dysphasia <input type="checkbox"/> Aphasia <input type="checkbox"/> Drooling or Inability to swallow <input type="checkbox"/> Throat pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Hoarse/Raspy <input type="checkbox"/> Other _____	<input type="checkbox"/> Dysphagia <input type="checkbox"/> Odynophagia (pain) <input type="checkbox"/> Dysphasia <input type="checkbox"/> Aphasia <input type="checkbox"/> Drooling or Inability to swallow <input type="checkbox"/> Throat pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Hoarse/Raspy <input type="checkbox"/> Other _____

Symptoms	Prior to Strangulation	During Strangulation	After Strangulation	At time of Assessment
Respiratory	<input type="checkbox"/> Stridor <input type="checkbox"/> Coughing <input type="checkbox"/> Hyper-ventilation <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Inability to tolerate supine position <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Stridor <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hyper-ventilation <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Inability to tolerate supine position <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Stridor <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hyper-ventilation <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Inability to tolerate supine position <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Stridor <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hyper-ventilation <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Inability to tolerate supine position <input type="checkbox"/> Other _____ _____
Gynecological	<input type="checkbox"/> Vaginal bleeding <input type="checkbox"/> Pregnant <input type="checkbox"/> Contractions <input type="checkbox"/> FHR _____ <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Vaginal bleeding <input type="checkbox"/> Pregnant <input type="checkbox"/> Contractions <input type="checkbox"/> FHR _____ <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Vaginal bleeding <input type="checkbox"/> Pregnant <input type="checkbox"/> Contractions <input type="checkbox"/> FHR _____ <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Vaginal bleeding <input type="checkbox"/> Pregnant <input type="checkbox"/> Contractions <input type="checkbox"/> FHR _____ <input type="checkbox"/> Other _____ _____ <input type="checkbox"/> EDC _____
Genitourinary	<input type="checkbox"/> Dysuria <input type="checkbox"/> Other _____	<input type="checkbox"/> Dysuria <input type="checkbox"/> Other _____	<input type="checkbox"/> Dysuria <input type="checkbox"/> Other _____	<input type="checkbox"/> Dysuria <input type="checkbox"/> Other _____
Gastrointestinal	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Anal/rectal bleeding <input type="checkbox"/> Abdominal pain _____ <small>(scale 0-10)</small>	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Anal/rectal bleeding <input type="checkbox"/> Abdominal pain _____ <small>(scale 0-10)</small>	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Anal/rectal bleeding <input type="checkbox"/> Abdominal pain _____ <small>(scale 0-10)</small>	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Anal/rectal bleeding <input type="checkbox"/> Abdominal pain _____ <small>(scale 0-10)</small>

Please indicate all injuries checked above on the body maps below.



Please indicate all injuries checked above on the body maps below.

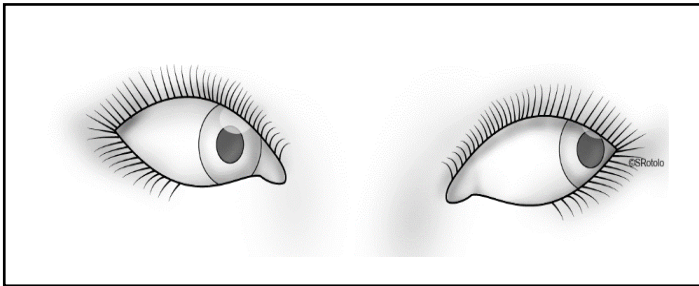
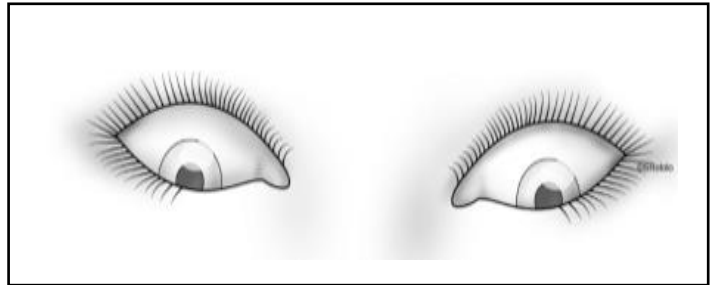
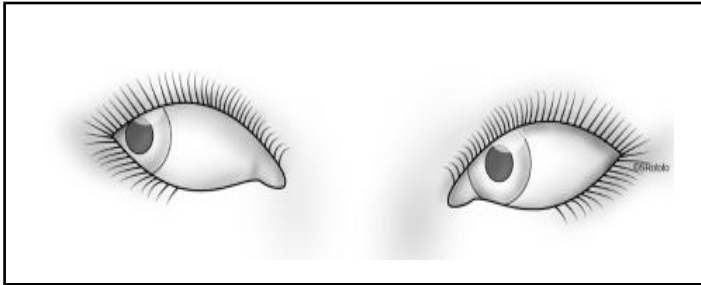
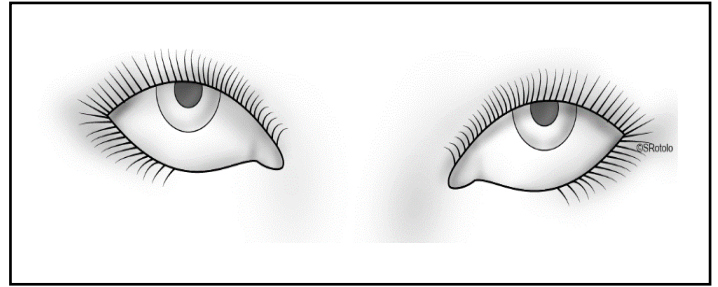
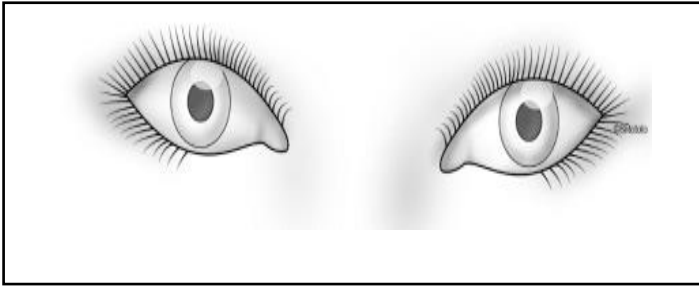


Photo-documentation of findings: Yes No

Notes _____

