

Documentation of Strangulation

Use this form when an assault victim reports being strangled or "choked".

INCIDENT INFORMATION

Case Number:		Date of Incident:		Today's Date:	
Form Completed by:		Responsible Officer's Name:			

VICTIM'S INFORMATION

Name:	DOB:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:
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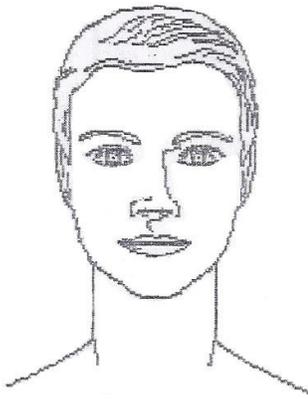
SUSPECT'S INFORMATION

Name:	DOB:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:
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SYMPTOMS AND/OR INTERNAL INJURY

Breathing Changes	Voice Changes	Swallowing Changes	Behavioral Changes	Other
<input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Unable to breathe <input type="checkbox"/> Coughing <input type="checkbox"/> Hyperventilation <input type="checkbox"/> Other:	<input type="checkbox"/> Raspy voice <input type="checkbox"/> Hoarse voice <input type="checkbox"/> Unable to speak/no voice <input type="checkbox"/> Only able to whisper <input type="checkbox"/> Other: <input type="checkbox"/> Tape: Voice change documented	<input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Painful to swallow <input type="checkbox"/> Neck pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomited/vomiting <input type="checkbox"/> Neck swollen <input type="checkbox"/> Drooling <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Other:	<input type="checkbox"/> Agitation <input type="checkbox"/> Amnesia <input type="checkbox"/> Hallucinations <input type="checkbox"/> Restlessness or Combativeness <input type="checkbox"/> Memory loss Lost consciousness: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Other:	<input type="checkbox"/> Dizziness <input type="checkbox"/> Headache <input type="checkbox"/> Light-headedness <input type="checkbox"/> Feeling faint <input type="checkbox"/> Involuntary urination <input type="checkbox"/> Involuntary defecation <input type="checkbox"/> Change/loss of hearing <input type="checkbox"/> Change/loss of vision <input type="checkbox"/> Other:

METHOD AND/OR MANNER OF STRANGULATION

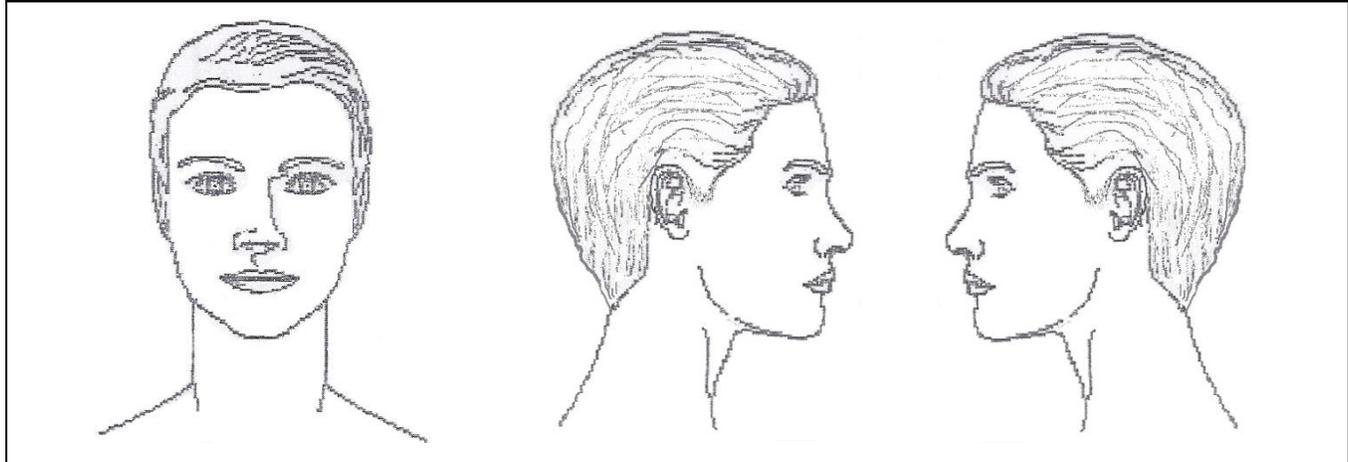
How many times was the victim strangled during this incident	<input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three or more	Indicate on diagram location of applied force 
How was the victim strangled? Check all that apply (combine multiple incidents)	<input type="checkbox"/> One hand: <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Hand <input type="checkbox"/> Two hands: <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Side <input type="checkbox"/> Forearm: <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Knee: <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Foot: <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Chokehold: <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm	
Was the victim also smothered?	If it can be determined, the type of chokehold: <input type="checkbox"/> Blood <input type="checkbox"/> Air	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, smothered with what?	

Use of ligature? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe ligature:	Was the ligature brought to the scene? <input type="checkbox"/> Yes <input type="checkbox"/> No Taken as evidence? <input type="checkbox"/> Yes <input type="checkbox"/> No	Photographed at scene? <input type="checkbox"/> Yes <input type="checkbox"/> No
How long was the victim strangled?	From 1 to 10, how hard was the suspect's grip? (Low) 1 2 3 4 5 6 7 8 9 10 (High)	Did the victim demonstrate the method of strangulation to you? <input type="checkbox"/> Yes <input type="checkbox"/> No

VISIBLE INJURIES

Face	Eyes/Eyelids	Nose	Ears	Mouth
<input type="checkbox"/> Red or Flushed <input type="checkbox"/> Petechiae <input type="checkbox"/> Scratch marks <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Abrasions <input type="checkbox"/> Neurological (i.e. droopiness/paralysis) <input type="checkbox"/> Other:	Petechiae: <input type="checkbox"/> Right eyeball <input type="checkbox"/> Left eyeball <input type="checkbox"/> Right eyelid <input type="checkbox"/> Left eyelid Subconjunctival Hemorrhage: <input type="checkbox"/> Right eyeball <input type="checkbox"/> Left eyeball <input type="checkbox"/> Vascular	<input type="checkbox"/> Bloody Nose <input type="checkbox"/> Broken nose (ancillary finding) <input type="checkbox"/> Petechiae Head <input type="checkbox"/> Petechiae (scalp) Ancillary Findings: <input type="checkbox"/> Hair pull <input type="checkbox"/> Bump <input type="checkbox"/> Skull fracture <input type="checkbox"/> Concussion	Petechiae: <input type="checkbox"/> Right external and/or ear canal <input type="checkbox"/> Left external and/or ear canal Bleeding from ear canal: <input type="checkbox"/> Right <input type="checkbox"/> Left Injury behind ear: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Bruising <input type="checkbox"/> Swollen tongue <input type="checkbox"/> Swollen lips <input type="checkbox"/> Cuts/ abrasions (ancillary finding) <input type="checkbox"/> Petechiae <input type="checkbox"/> Other:
Under Chin	Chest	Shoulders	Neck	Hands
<input type="checkbox"/> Redness <input type="checkbox"/> Petechiae <input type="checkbox"/> Scratch marks <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Abrasions <input type="checkbox"/> Other:	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Abrasions <input type="checkbox"/> Other:	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Abrasions <input type="checkbox"/> Elbow abrasions <input type="checkbox"/> Other:	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Fingernail impressions <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Swelling <input type="checkbox"/> Ligature Mark <input type="checkbox"/> Pattern Injury <input type="checkbox"/> Other:	<input type="checkbox"/> Scratch marks <input type="checkbox"/> Fingernail debris <input type="checkbox"/> Swelling <input type="checkbox"/> Other:

USE FACE AND NECK DIAGRAMS TO MARK VISIBLE INJURIES



Any pre-existing injuries on victim? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe:
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PHOTOGRAPHS

Injury photos (number taken and by whom):

Crime scene photos (number taken and by whom):

(Remember: One full body photograph and multiple close-up photos of injuries at different angles as needed)

MEDICAL ATTENTION

Did EMS respond to evaluate the victim? Yes No

Was a medical waiver obtained? Yes No

ADDITIONAL INFORMATION FROM THE VICTIM

(Use additional pages as necessary)

1. Did the suspect strangle the victim multiple times? Yes No
2. Did the suspect use multiple methods of strangulation? Yes No
If yes, what methods? _____
3. Is the suspect **RIGHT** or **LEFT** handed? (circle one)
4. Was the suspect wearing jewelry? Yes No If yes, what? _____
5. What did the suspect say while strangling the victim, before and/or after? _____

6. What was the suspect's demeanor during the strangulation? _____

7. Describe what the suspect's face looked like during the strangulation: _____

8. While being strangled, was the victim: Shaken? Yes No Straddled? Yes No
Held against a wall? Yes No
Head pounded against something? Yes No If yes, what? _____
9. What did the victim think was going to happen? _____

10. How or why did the suspect stop strangling the victim? _____

11. Describe prior incidents of strangulation, prior domestic violence, and/or prior threats: _____

13. Did the victim attempt to protect herself/himself? (verbally and physically) _____

14. Did the victim injure the suspect? Yes No If yes, describe what and how: _____

15. Did the victim say anything to the suspect? Yes No What? _____

16. Could the suspect see the victim's face? Yes No
17. Did the victim lose consciousness during the strangulation? Yes No If yes, how does the victim know he or she lost consciousness? _____
18. Did the victim have any changes or loss of hearing during and/or after the strangulation? Yes No If yes, describe the changes? _____
19. Did the victim have any changes or loss of vision during and/or after the strangulation? Yes No If yes, describe the changes? _____