

**SEMINOLE NATION**  
**DOMESTIC VIOLENCE INTAKE**

**Client Information**

Date: \_\_\_\_\_ Client ID: \_\_\_\_\_

Who referred you to Seminole Nation?  
\_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Alternative Phone \_\_\_\_\_

Is it ok to contact you at these numbers? Yes \_\_\_\_\_ No \_\_\_\_\_

DOB \_\_\_\_\_ SSN: \_\_\_\_\_

Race/Ethnicity \_\_\_\_\_ What tribe? \_\_\_\_\_

Physical Description of Client \_\_\_\_\_

**Note: Include Height, Weight, Hair Color, Tattoos, and Distinguishing Characteristics**

Current Marital Status \_\_\_\_\_ Military History \_\_\_\_\_

Current Employer/Source of Income \_\_\_\_\_

Annual Income \_\_\_\_\_ # Dependant on Income \_\_\_\_\_

**Circle:** Employment Status: Full Time Part-Time Unemployed Not in labor force

**Circle:** Benefits Received: TANF Food Stamps SSI SSDI V/A

Currently a student? \_\_\_\_\_ # of Years Completed \_\_\_\_\_

**Family/Relationships**

Current Living Arrangements:  
\_\_\_\_\_

List children in chart below:

Name	Age	Race/Ethnicity	Gender	With whom do they live?	Ever been a victim of DV/SV?

**Drug and Alcohol Screening**

Have you ever used illegal drugs? Yes\_\_\_\_\_ No\_\_\_\_\_ Type of Drugs\_\_\_\_\_

Last Use\_\_\_\_\_ Received Treatment? \_\_\_\_\_

Have you ever abused prescription drugs? Yes\_\_\_\_\_ No\_\_\_\_\_

Last Use\_\_\_\_\_

Have you ever used alcohol excessively? Yes\_\_\_\_\_ No\_\_\_\_\_ Last Use\_\_\_\_\_

Are you presently under the influence of drugs or alcohol? Yes\_\_\_\_\_ No\_\_\_\_\_

Age First Used Alcohol, Drugs, or Prescription Drugs\_\_\_\_\_

Attending AA/NA? \_\_\_\_\_

**Pertinent Medical Information**

List all pertinent medical information\_\_\_\_\_

\_\_\_\_\_  
Current physician\_\_\_\_\_

Is client currently pregnant? Yes\_\_\_\_\_ No\_\_\_\_\_ Number of Months\_\_\_\_\_

Any complications with the pregnancy? \_\_\_\_\_

Is the client under the care of a mental health professional? Yes\_\_\_\_\_ No\_\_\_\_\_

Name of clinician \_\_\_\_\_

Phone \_\_\_\_\_

Diagnosis \_\_\_\_\_

Medications \_\_\_\_\_

Has client ever attempted suicide? \_\_\_\_\_ Method \_\_\_\_\_

Last attempt \_\_\_\_\_ Screening Assessment \_\_\_\_\_

**Special Food/Dietary Needs:**

List all dietary needs, allergies, pregnancy considerations for adult and children:

\_\_\_\_\_  
\_\_\_\_\_

**Allergies to Medicines:**

List all allergies for adult and children:

\_\_\_\_\_

**Perpetrator Information**

Was the client the primary victim? \_\_\_\_\_

Relationship to abuser? \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_ Race \_\_\_\_\_

Physical  
Description \_\_\_\_\_  
\_\_\_\_\_

Note: (Include height, weight, hair color, any facial hair, and distinguishing characteristics)

Employer \_\_\_\_\_ Hours Worked \_\_\_\_\_

Vehicle Information \_\_\_\_\_

(Year, Make, Model, Color, Distinguishing Marks, Tag Number)

Does perpetrator have access to weapons?  
\_\_\_\_\_

Does perpetrator have outstanding warrants?  
\_\_\_\_\_

Do you have a VPO against perpetrator? Yes \_\_\_\_\_ No \_\_\_\_\_

Case Number \_\_\_\_\_

Does perpetrator have a history of mental illness? Yes \_\_\_\_\_ No \_\_\_\_\_

Diagnosis \_\_\_\_\_

Does perpetrator have a history of substance abuse? Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_

Substances of  
Choice \_\_\_\_\_

**Presenting Problem:**

Date of last incident \_\_\_\_\_

History/Nature of  
Abuse \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long has abuse been occurring? \_\_\_\_\_

Has perp. ever strangled you? \_\_\_\_\_

Has perpetrator ever used a weapon against you? \_\_\_\_\_ Type of  
Weapon \_\_\_\_\_

Types of abuse experienced with this perpetrator: (Check all that apply)

Physical \_\_\_\_\_ Psychological \_\_\_\_\_ Verbal \_\_\_\_\_ Sexual \_\_\_\_\_

Stalking \_\_\_\_\_ Other \_\_\_\_\_ Explanation \_\_\_\_\_

Number of times police were called? \_\_\_\_\_

Reports filed? \_\_\_\_\_

Convictions? \_\_\_\_\_

Ever received medical attention for injuries? \_\_\_\_\_

Who else have you informed about the abuse?  
\_\_\_\_\_

With this signature, I am signifying that an advocate has provided me with a copy of the following documents, fully explained each document, and answered all of my questions. My signature signifies agreement to follow all rules as stated in the Client Rules and Statement of Understanding.

**Document Client initials Advocate Initials**

- 1. Client Rules
- 2. Client Rights
- 3. Statement of Understanding

\_\_\_\_\_ Client Signature and Date

\_\_\_\_\_ Advocate Signature and Date

**Release of Liability**

I agree NOT to hold Seminole Nation liable for any injuries sustained by me or my children while receiving services, being transported by Seminole Nation staff or volunteers, or participating in any outdoor or recreational activities. I will NOT hold Seminole Nation liable for any loss of personal property due to theft, disaster, or from a reasonable search and seizure. My signature indicates my agreement to accept services, including transportation, with the knowledge of these exemptions.

\_\_\_\_\_ Client Signature and Date

**Emergency Medical Care**

With my signature, I agree to allow a Seminole Nation staff member or volunteer transport me and/or my children to the nearest medical facility in the case of a medical emergency in which I am incapacitated or unavailable to accompany my children for emergency care. In the instances where ambulance assistance is needed, I authorize Seminole Nation advocates to call 911 to request an ambulance on my behalf. Seminole Nation advocates may contact individuals listed on my emergency notification form to inform them of my condition. In signing this form, I shall in no way hold Seminole Nation responsible for any medical costs incurred.

\_\_\_\_\_ Client Signature and Date

## **Client Rules**

1. Under no circumstances are you to disclose the identity or personal information of any individual seen at Seminole Nation.
2. Group session cannot be taped for any reason.
3. Outside individuals will be asked to wait outside during group session.
4. I agree that violence, including verbal aggression, is strictly prohibited at Seminole Nation.
5. I agree that I will not come to any Seminole Nation locations while under the influence of drugs or alcohol.

## **Client Rights**

As a client of Seminole Nation:

1. You have and enjoy all constitutional and statutory rights of all citizens of the State of Oklahoma and the U.S., unless abridged through due process of law by a court of competent jurisdiction.
2. You have the right to be treated with respect and dignity. This shall be construed to protect and promote human dignity and respect for individual dignity.
3. You have the right to a safe, sanitary, and humane living environment.
4. You have the right to humane psychological environment protecting you from harm, abuse, and neglect.
5. You have the right to receive services suited to your needs without regard to your race, religion, sex, ethnic origin, age, and any condition of disability, legal status, or ability to pay for the services.
6. You have the right to communicate with a relative, friend, clergy, or attorney, by telephone or mail, at the expense of the program if you are indigent.
7. You retain the right to confidential communication with an attorney, personal physician, or clergy.
8. You have the right to uncensored, private communications including, but not limited to, letters and telephone calls. Copies of any personal letter, sent or received, by you shall not be kept in your client record without your written consent. **Unless superseded by provisions in 75:15-4-3**
9. You will not be neglected or sexually, physically, verbally, or otherwise abused.
10. You have the right to practice your own religious beliefs, and be afforded the opportunity for religious worship that does not infringe upon the health or safety of others. You shall not be coerced into engaging in, or refraining from, any personal religious activity, practice, or belief.

11. You have the right to be provided with prompt, competent, appropriate services and an individualized service plan.

A. You have the opportunity to participate in developing your service plan.

B. You have the right to consent, or refuse to consent, to the proposed services.

12. Your records are confidential. The exceptions breaking confidentiality are reporting of child abuse, with your written, informed consent, by order of the court for good cause shown, or in the case that you pose a danger to yourself or others.

13. You have the right to refuse to participate in any research project or medical experiment without informed consent of the client, as defined by law. A refusal to participate will not affect the services available to you.

14. You have the right to assert grievances with respect to any alleged infringement of these stated rights of clients, or any other subsequently statutorily granted rights.

15. You will not be retaliated against, or subject to, any adverse conditions or services solely or partially because of having asserted your rights as stated.

16. You have the right to review your own records, or authorize your attorney or others to do so. You have the right that all information and records regarding you shall be treated as confidential.

17. You have the right to know why services are refused and can expect an explanation concerning the reason you were refused certain services.

**Please read or have read to you the following statements. Please acknowledge your understanding of these statements and have the advocate answer any questions you have.**

1. I am receiving services from Seminole Nation of my own free will.

2. If at any point during my services at Seminole Nation an advocate feels that I am in need of emergency medical attention or emergency mental health attention, I agree to be examined and treated by a physician or mental health professional. I understand that Seminole Nation will not accept responsibility for any expenses incurred.

3. I understand that Seminole Nation advocates are mandatory reporters of child abuse, child neglect, potential suicidal or homicidal tendencies, and any abuse of an elderly or incapacitated adult. These instances over-ride confidentiality.

4. I understand that in the instance that a court orders the release of any information regarding myself or my children, Seminole Nation advocates have no choice but to release that information and is an exception to confidentiality.

5. I understand that information related to me, my children and any services received by Seminole Nation are protected by State and Federal Laws and are confidential. The only

exceptions are the ones listed above and in the instance that I have signed "Consent to Release Confidential Information."

6. I understand that at no point shall I release the identity or information of any client or advocate at Seminole Nation and if I do so, understand that I may be subject to termination from services and/or legal action.

7. I understand that my services at Seminole Nation is determinant upon my ability to follow Seminole Nation rules and the ability to create a non-violent atmosphere free of physical abuse, sexual abuse and verbal abuse. In the event that I violate this statement of understanding, I realize that I will be terminated from services immediately.

\_\_\_\_\_ **Client Signature and Date**

\_\_\_\_\_ **Staff Signature and Date**



**Emergency Contact(s)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Relationship: \_\_\_\_\_



