

SCOPE-6: Screening for Coercive Control, Physical, and Emotional abuse

Instructions:

For each item, please indicate if you have experienced the behavior. If "Yes," specify the frequency within the past 12 months.

1. Physical Abuse

Has a partner ever physically harmed you (e.g., pushed, slapped, hit, kicked, or used a weapon)?

Yes No

If Yes, frequency: Once Occasionally Frequently

2. Threats or Intimidation

Has a partner ever threatened to harm you, your children, pets, or other individuals close to you?

Yes No

If Yes, frequency: Once Occasionally Frequently

3. Emotional or Psychological Abuse

Has a partner ever insulted, belittled, humiliated, or undermined your self-worth?

Yes No

If Yes, frequency: Once Occasionally Frequently

4. Coercive Control

Does a partner monitor your communications, restrict your access to finances/transportation, or dictate who you see and where you go?

Yes No

If Yes, frequency: Once Occasionally Frequently

5. Sexual Abuse

Has a partner ever forced or coerced you into sexual acts or reproductive choices against your will?

Yes No

If Yes, frequency: Once Occasionally Frequently

6. Fear

Do you currently feel afraid of your partner or feel you must "walk on eggshells" to avoid conflict?

Yes No

If Yes, frequency: Once Occasionally Frequently

Follow-up and Support

Would you like to discuss these results with a healthcare professional or receive information regarding support services and safety planning?

Yes No

Note:

This form is based on best practices and validated IPV screening tools, and is designed for brevity, clarity, and direct assessment of intimate partner violence. For clinical or forensic use, always follow local protocols for positive screenings, safety planning, and documentation.

For Administrative Use Only:

Provider Name/ID: _____ Date: _____

Action Taken: Safety Plan Provided Referral Made Immediate Intervention Required