

***DIVISION OF POLICE***

**ATTEMPTED STRANGULATION WORKSHEET**

Name of Victim \_\_\_\_\_ Case # \_\_\_\_\_

Date of Interview \_\_\_\_\_ Date of Incident \_\_\_\_\_

1. How was the victim strangled?

One hand (R or L)       Two hands       Forearm (R or L)       Knee/Foot

Object/Ligature (Describe) \_\_\_\_\_

How long? \_\_\_\_\_seconds      \_\_\_\_\_minutes

Pinned or banged against wall?       Straddled?       Smothered?

Shaken while being strangled?       Head pounded against wall, floor or ground?

From 1 to 10, how hard was suspect's grip? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

From 1 to 10, how painful was it? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Multiple attempts \_\_\_\_\_  Multiple methods \_\_\_\_\_

Was pressure continuous? \_\_\_\_\_

Strangulation occurred from **FRONT** or **REAR**

Victim rendered unconscious?      How ? \_\_\_\_\_seconds      \_\_\_\_\_minutes

2. Where did the incident take place? \_\_\_\_\_

3. Did victim try to get free or protect him/herself? \_\_\_\_\_ Describe \_\_\_\_\_

4. Was victim pregnant at the time?      NO      YES # months \_\_\_\_\_

5. Is suspect RIGHT or LEFT handed? (Circle one)       Suspect was wearing ring(s)

6. How or why did suspect stop strangling victim? \_\_\_\_\_

7. What did suspect say during strangulation? \_\_\_\_\_

8. What did victim think was going to happen? \_\_\_\_\_

9. What did suspect's face look like during strangulation? \_\_\_\_\_

## Medical Information/Observations

Please identify for each symptom whether the specific symptom appeared at the time of the incident (ATI), since the incident (SI), or currently (C). More than one box may be checked if applicable.

|                                                 | At Time of Incident      | Since Incident           | Currently                |
|-------------------------------------------------|--------------------------|--------------------------|--------------------------|
| <b>Breathing Changes:</b>                       |                          |                          |                          |
| <input type="checkbox"/> Difficulty breathing   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hyperventilating       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Unable to breathe      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Voice Changes:</b>                           |                          |                          |                          |
| <input type="checkbox"/> Raspy Voice            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hoarse Voice           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Unable to speak        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Swallowing Changes:</b>                      |                          |                          |                          |
| <input type="checkbox"/> Trouble swallowing     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Painful to swallow     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck pain              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Nausea                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Vomiting               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Behavioral Changes:</b>                      |                          |                          |                          |
| <input type="checkbox"/> Amnesia                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Agitation              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hallucinations         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Other:</b>                                   |                          |                          |                          |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Fainting               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Involuntary urination  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Involuntary defecation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

At the time of conducting this interview, did the interviewer observe the following about the victim:

### Face:

- Red of flushed     Show petechiae     Scratch marks     Bruising

### Eyes and Eyelids:

- Petechiae to **R** and/or **L** eyeball     Petechiae to **R** and/or **L** eyelid
- Bloody **R** and/or **L** eyeball



