Teen Dating Violence
Assessment Questions

Client's Name: _____ Date: _____

Associate's Name: _____ Date: _____

School Assessment	YES	NOT SURE	NO
Have my grades fallen since I've been in this relationship			
Have I ever missed, or been late to school because of a fight with my partner			
Have I ever quit a school group or club so I could spend that time with my partner			
Work Assessment	**YES**	**NOT SURE**	**NO**
Does my partner control my money			
Do I talk to my partner on the phone so much while at work that it gets in the way of my job			
Has my partner ever shown up at my job to "check up" on me because of jealousy			
Physical Health	**YES**	**NOT SURE**	**NO**
Have I ever had cuts, bruises, or other injuries as a result of a fight with my dating partner			
Have I gained or lost a significant amount of weight since I've been in this relationship			
Have I had any unplanned pregnancies from my dating partner			
Emotional Health	**YES**	**NOT SURE**	**NO**
Do I ever think that I could not go on without my dating partner			
Do I feel more stressed, depressed, or anxious since I have been in this relationship			
Do I cry more or less frequently since I've been in this relationship			
Drugs/Alcohol Use	**YES**	**NOT SURE**	**NO**
Have I started/increased smoking, drinking, or using drugs since I've been in this relationship			
Does my partner pressure me to use drugs or alcohol			
Do I ever use drugs to feel more comfortable around my partner			
Family and other Relationships	**YES**	**NOT SURE**	**NO**
Have I grown apart from my family and friends since I've been in this relationship			
Does my partner act jealous of my family and friends and try to keep me from them			
Do I lie to my friends and family to cover up for my partner			

Teen Dating Violence
Screening Questions

Client's Name:_____ Date:_____

Associate's Name:_____ Date: _____

1. Do you or your partner call each other names, make each other feel useless or dumb, or constantly put each other down: (comments) _____

_____

_____

_____

YES	NO

2. Are you or your partner extremely jealous: (comments) _____

_____

_____

_____

YES	NO

3. Is sex or unwanted sexual contact forced in your relationship: (comments)

_____

_____

_____

YES	NO

4. Have you ever experienced or witnessed violence in a dating relationship: (comments) _____

_____

_____

YES	NO

5. Have you or your partner ever shoved, grabbed, pinched, held down, kicked, or punched each other: (comments) _____

_____

_____

YES	NO

6. Do you or your partner use fear to keep each other in the relationship: (comments) _____

_____

_____

YES	NO