





ACTS DESCRIBED BY VICTIM (note method/manner)					
<b>Did the victim:</b> <ul style="list-style-type: none"> <li>• Scratch the assailant(s)</li> <li>• Bite the assailant(s)</li> <li>• Hit the assailant(s)</li> <li>• Kick the assailant(s)</li> </ul>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Describe::
Any injuries to assailant(s) resulting in bleeding?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> Unsure	Location:
<b>Did the assailant(s):</b> <ul style="list-style-type: none"> <li>• Scratch the victim</li> <li>• Bite the victim</li> <li>• Hit or kick the victim</li> <li>• Kiss and/or lick the victim</li> </ul>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Describe:
Any injuries to victim resulting in bleeding?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> Unsure	Location:
<b>Did the victim:</b> <ul style="list-style-type: none"> <li>• Touch the assailant's penis/scrotum</li> <li>• Touch the assailant's anus</li> <li>• Touch the assailant's breasts</li> <li>• Touch the assailant's external genitalia</li> </ul>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Describe:
<b>Did the assailant(s):</b> <ul style="list-style-type: none"> <li>• Touch the victim's breasts</li> <li>• Touch the victim's external genitalia</li> <li>• Touch the victim's anus</li> <li>• Touch the victim's penis/scrotum</li> </ul>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Describe:
<b>Did the assailant(s):</b> <ul style="list-style-type: none"> <li>• Masturbate the victim?</li> <li>• Force victim to masturbate him/herself?</li> <li>• Force victim to masturbate assailant?</li> </ul>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Describe:
Did the assailant(s) masturbate on/near victim?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Describe:
Was there oral contact of the victim's genitalia by the assailant(s)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Location:
Was there oral contact of the assailant's genitalia by the victim?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Location:
Was there penetration of victim's genital opening by the assailant(s)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penis <input type="checkbox"/> Finger <input type="checkbox"/> Foreign object <input type="checkbox"/> Other
Was there penetration of victim's anal opening by the assailant(s)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penis <input type="checkbox"/> Finger <input type="checkbox"/> Foreign object <input type="checkbox"/> Other
Was a lubricant used?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> Unsure	Type:
Was a condom used?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	
Was the condom discarded?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> Unsure	Location:
Did ejaculation occur?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> Unsure	Location: <input type="checkbox"/> Mouth <input type="checkbox"/> Vagina <input type="checkbox"/> Anus/Rectum <input type="checkbox"/> Body surface <input type="checkbox"/> On clothing <input type="checkbox"/> On bedding <input type="checkbox"/> Other _____
<b>Position(s) during assault:</b> <input type="checkbox"/> Supine <input type="checkbox"/> Standing <input type="checkbox"/> Prone <input type="checkbox"/> Sitting <input type="checkbox"/> Lying on side (right/left) <input type="checkbox"/> Unknown <input type="checkbox"/> Other:					

Officer's Initials: \_\_\_\_\_

Examiner's Initials: \_\_\_\_\_

METHODS EMPLOYED BY ASSAILANT(S)					
Threats or fear/intimidation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> Unsure	Describe:
Grabbing, grasping, or holding?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Location:
Physical blows?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Location:
Was a weapon or other object used?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Type:
Were physical restraints used?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Type:
Burns (chemical or thermal)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Location:
Choking/Strangulation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	
Involuntary ingestion of alcohol or drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure	Type: <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs
Other:	Describe:				

**ALCOHOL AND DRUG INFORMATION:**

Was alcohol used by the victim at the time surrounding the assault?  Unknown  No  Yes If yes, describe: \_\_\_\_\_

Were drugs used by the victim at the time surrounding the assault?  Unknown  No  Yes If yes, describe: \_\_\_\_\_

Was victim menstruating at the time of the assault?  No  Yes

Has the victim started her menses since the assault?  No  Yes How many hours/days after: \_\_\_\_\_

HYGIENE/ACTIVITY (since the assault and prior to the exam)			VICTIM'S DESCRIPTION
Ate	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Drank	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Brushed teeth	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Gargled/Rinsed mouth	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Showered/Bathed/Steamed (circle one)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Number of times:
Wiped genitals	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, with what:
Washed genitals	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, with what:
Douched/Enema	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Urinated	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Number of times:
Bowel movement	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Number of times:
Vomited	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Inserted a <input type="checkbox"/> tampon <input type="checkbox"/> diaphragm <input type="checkbox"/> sponge	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Is victim still wearing it <input type="checkbox"/> Yes <input type="checkbox"/> No (discarded)
Used a <input type="checkbox"/> pad or <input type="checkbox"/> panty liner	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Is victim still wearing it <input type="checkbox"/> Yes <input type="checkbox"/> No (discarded)
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Officer's Initials: \_\_\_\_\_

Examiner's Initials: \_\_\_\_\_

CLOTHING WORN AT TIME OF EXAM	
Condition/Appearance: <input type="checkbox"/> Clean <input type="checkbox"/> Intact <input type="checkbox"/> Dirty <input type="checkbox"/> Wet <input type="checkbox"/> Torn <input type="checkbox"/> Apparent blood	Clothing worn at time of exam: (List) <input type="checkbox"/> Shirt/T-shirt Describe: _____ <input type="checkbox"/> Jeans/Pants Describe: _____ <input type="checkbox"/> Coat/Jacket Describe: _____ <input type="checkbox"/> Underwear Describe: _____ <input type="checkbox"/> Bra Describe: _____ <input type="checkbox"/> Socks/Shoes Describe: _____ <input type="checkbox"/> Other Describe: _____
Is the clothing worn at the time of the exam the same clothing worn at the time of the offense? <input type="checkbox"/> Yes (same as above) <input type="checkbox"/> No If no, list the clothing items worn during the offense below:	
CLOTHING WORN AT TIME OF ASSAULT	
Condition/Appearance: <input type="checkbox"/> Clean <input type="checkbox"/> Intact <input type="checkbox"/> Dirty <input type="checkbox"/> Wet <input type="checkbox"/> Torn <input type="checkbox"/> Apparent blood	Clothing worn at time of assault: (List) <input type="checkbox"/> Shirt/T-shirt Describe: _____ <input type="checkbox"/> Jeans/Pants Describe: _____ <input type="checkbox"/> Coat/Jacket Describe: _____ <input type="checkbox"/> Underwear Describe: _____ <input type="checkbox"/> Bra Describe: _____ <input type="checkbox"/> Socks/Shoes Describe: _____ <input type="checkbox"/> Other Describe: _____
If the victim has changed clothing since the assault, were any items laundered? <input type="checkbox"/> No <input type="checkbox"/> Yes How: <input type="checkbox"/> Cold-water wash <input type="checkbox"/> Hot-water wash <input type="checkbox"/> Dry-cleaned Was detergent used? <input type="checkbox"/> Yes <input type="checkbox"/> No Was a bleaching agent used? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Where is the clothing now? <input type="checkbox"/> Unsure <input type="checkbox"/> At scene <input type="checkbox"/> With victim <input type="checkbox"/> Given to law enforcement <input type="checkbox"/> Other	

**GYNECOLOGICAL HISTORY:**

Has the victim had recent consensual sexual activity **prior to the assault**?  No  Yes

- Vaginal (within the last 7 days)  No  Yes Date: \_\_\_\_\_ With: \_\_\_\_\_
- Vaginal (within the last 3 weeks)  No  Yes Date: \_\_\_\_\_ With: \_\_\_\_\_
- Anal (within the past 72 hours)  No  Yes Date: \_\_\_\_\_ With: \_\_\_\_\_
- Anal (within the last 7 days)  No  Yes Date: \_\_\_\_\_ With: \_\_\_\_\_
- Oral (received within the past 24 hours)  No  Yes Date: \_\_\_\_\_ With: \_\_\_\_\_
- Oral (given within the past 24 hours)  No  Yes Date: \_\_\_\_\_ With: \_\_\_\_\_
- Did ejaculation occur?  No  Yes Was a barrier used?  No  Yes Type: \_\_\_\_\_

**Since the assault**, has the victim had consensual sexual activity?  No  Yes Date: \_\_\_\_\_ Time: \_\_\_\_\_

Type:  Vaginal  Anal  Oral With: \_\_\_\_\_

Officer's Initials: \_\_\_\_\_

Examiner's Initials: \_\_\_\_\_

SUSPECT INFORMATION: Number of assailants:  1  2  3  4

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1. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_ Gender:  Male  Female

**RELATIONSHIP TO VICTIM: (Check/circle all that apply)**

Unknown  Known  Stranger  Spouse (current/former)  Partner (current/former)  Relative  Friend  Other: \_\_\_\_\_

**PHYSICAL CHARACTERISTICS:**

Hair color:  Blonde  Brown  Black  Red  Other \_\_\_\_\_ Length:  Short  Medium  Long  Shaved/Bald

Facial hair:  No  Yes If yes, type: \_\_\_\_\_

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2. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_ Gender:  Male  Female

**RELATIONSHIP TO VICTIM: (Check/circle all that apply)**

Unknown  Known  Stranger  Spouse (current/former)  Partner (current/former)  Relative  Friend  Other: \_\_\_\_\_

**PHYSICAL CHARACTERISTICS:**

Hair color:  Blonde  Brown  Black  Red  Other \_\_\_\_\_ Length:  Short  Medium  Long  Shaved/Bald

Facial hair:  No  Yes If yes, type: \_\_\_\_\_

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3. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_ Gender:  Male  Female

**RELATIONSHIP TO VICTIM: (Check/circle all that apply)**

Unknown  Known  Stranger  Spouse (current/former)  Partner (current/former)  Relative  Friend  Other: \_\_\_\_\_

**PHYSICAL CHARACTERISTICS:**

Hair color:  Blonde  Brown  Black  Red  Other \_\_\_\_\_ Length:  Short  Medium  Long  Shaved/Bald

Facial hair:  No  Yes If yes, type: \_\_\_\_\_

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4. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_ Gender:  Male  Female

**RELATIONSHIP TO VICTIM: (Check/circle all that apply)**

Unknown  Known  Stranger  Spouse (current/former)  Partner (current/former)  Relative  Friend  Other: \_\_\_\_\_

**PHYSICAL CHARACTERISTICS:**

Hair color:  Blonde  Brown  Black  Red  Other \_\_\_\_\_ Length:  Short  Medium  Long  Shaved/Bald

Facial hair:  No  Yes If yes, type: \_\_\_\_\_

Officer's Initials: \_\_\_\_\_

Examiner's Initials: \_\_\_\_\_