

**FORT HOOD POLICE DEPARTMENT  
FAMILY VIOLENCE ASSAULT SUPPLEMENT**

(The proponent for this form is DES.)

**PRIVACY ACT SYSTEMS NOTICE**

**AUTHORITY:** Title 10, USC, Sec 301; Title 5 USC, Sec 2951; EO 9397, 22 Nov 1943.  
**PRINCIPAL PURPOSE:** To provide law enforcement officials with a means by which information may be accurately identified.  
**ROUTINE USES:** Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.  
**DISCLOSURE:** Disclosure of your social security number is voluntary.

TEMP MPR NO: \_\_\_\_\_ DATE: \_\_\_\_\_ MILITARY POLICE REPORT NO: \_\_\_\_\_

**VICTIM:**

1. Name: \_\_\_\_\_ 2. DOB: \_\_\_\_\_ 3. SSN: \_\_\_\_\_

4. Grade: \_\_\_\_\_ 5. Sex: M / F \_\_\_\_\_ 6. Race: \_\_\_\_\_

7. Address: \_\_\_\_\_

8. Telephone: \_\_\_\_\_ 9. Email: \_\_\_\_\_

10. Was this reported via 911?  Yes  No

11. Was a statement taken?  Yes  No

12. Was a medical release signed?  Yes  No

13. Information given:  Emergency PO sheet  Notice to victims of family violence (DD Form 2701)

<p>14. Relationship to suspect:</p> <p><input type="checkbox"/> Spouse <input type="checkbox"/> Dating/engaged <input type="checkbox"/> Former spouse <input type="checkbox"/> Former dating <input type="checkbox"/> Cohabitants <input type="checkbox"/> Parent of child from relationship <input type="checkbox"/> Former cohabitants Length of relationship: _____</p>	<p>15. Medical treatment:</p> <p><input type="checkbox"/> None <input type="checkbox"/> Refused medical treatment <input type="checkbox"/> Will seek own treatment <input type="checkbox"/> Paramedics called: unit number _____ <input type="checkbox"/> Transported to hospital: Name of hospital _____</p>
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16. Check the following conditions about the victim:

<p>16a. Physical</p> <p><input type="checkbox"/> Complaint of pain <input type="checkbox"/> Abrasions <input type="checkbox"/> Minor cuts <input type="checkbox"/> Lacerations <input type="checkbox"/> Bruising <input type="checkbox"/> Fractures <input type="checkbox"/> Concussion <input type="checkbox"/> Choked <input type="checkbox"/> Loose hair</p>	<p>16b. Emotional</p> <p><input type="checkbox"/> Angry <input type="checkbox"/> Fearful <input type="checkbox"/> Apologetic <input type="checkbox"/> Hysterical <input type="checkbox"/> Nervous <input type="checkbox"/> Crying <input type="checkbox"/> Calm <input type="checkbox"/> Threatening <input type="checkbox"/> Uncooperative <input type="checkbox"/> Combative <input type="checkbox"/> Intoxicated</p>	<p>16c. Appearance</p> <p><input type="checkbox"/> Disorderly clothing <input type="checkbox"/> Torn/ripped clothing <input type="checkbox"/> Bloody clothing <input type="checkbox"/> Smearred makeup <input type="checkbox"/> Tangled/messy hair <input type="checkbox"/> Other (explain)</p>
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17. Verbal statements made at scene: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<p>18. Information about present and past abuse:</p> <p><input type="checkbox"/> Prior unreported domestic violence (# _____ incidents) <input type="checkbox"/> Prior reported domestic violence (# _____ incidents) <input type="checkbox"/> Strangulation/choking (# _____ incidents) <input type="checkbox"/> Prior separations (# over 24 hours _____) <input type="checkbox"/> Escalation violence</p>	<p>19. Weapons used (this time or in the past):</p> <p><input type="checkbox"/> Knife <input type="checkbox"/> Bat/club <input type="checkbox"/> Handgun <input type="checkbox"/> Other: _____ <input type="checkbox"/> Rifle <input type="checkbox"/> Shotgun</p>
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**SUSPECT:**

20. Name: \_\_\_\_\_ 21. DOB: \_\_\_\_\_ 22. SSN: \_\_\_\_\_

23. Grade: \_\_\_\_\_ 24. Sex: M / F \_\_\_\_\_ 25. Race: \_\_\_\_\_

26. Address: \_\_\_\_\_

27. Telephone: \_\_\_\_\_ 28. Email: \_\_\_\_\_

29. Statement taken?  Yes  No

30. Medical treatment:

None  Transported to hospital

Refused medical treatment Name of hospital: \_\_\_\_\_

Will seek own treatment

Paramedics called: unit number \_\_\_\_\_

31. Verbal statements made at scene: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

32. Check all of the following that apply:

<p>32a. Physical:</p> <p><input type="checkbox"/> Complaint of pain <input type="checkbox"/> Abrasions</p> <p><input type="checkbox"/> Minor cuts <input type="checkbox"/> Lacerations</p> <p><input type="checkbox"/> Bruising <input type="checkbox"/> Fractures</p> <p><input type="checkbox"/> Concussion <input type="checkbox"/> Choked</p> <p><input type="checkbox"/> Loose hair</p>	<p>32b. Emotional:</p> <p><input type="checkbox"/> Angry <input type="checkbox"/> Hysterical</p> <p><input type="checkbox"/> Apologetic <input type="checkbox"/> Crying</p> <p><input type="checkbox"/> Nervous <input type="checkbox"/> Threatening</p> <p><input type="checkbox"/> Calm <input type="checkbox"/> Intoxicated</p> <p><input type="checkbox"/> Uncooperative <input type="checkbox"/> Combative</p> <p><input type="checkbox"/> Fearful</p>	<p>32c. Appearance:</p> <p><input type="checkbox"/> Disorderly clothing</p> <p><input type="checkbox"/> Torn/ripped clothing</p> <p><input type="checkbox"/> Bloody clothing</p> <p><input type="checkbox"/> Smearred makeup</p> <p><input type="checkbox"/> Tangled/messy hair</p> <p><input type="checkbox"/> Other (explain) _____</p>
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33. Names and ages of children:

Name	Age	Gender	Relationship to victim	Witness?

34. Scene:

<p>34a. Photos:</p> <p><input type="checkbox"/> Victim</p> <p><input type="checkbox"/> Suspect</p> <p><input type="checkbox"/> Scene</p> <p><input type="checkbox"/> Taken by: _____</p> <p><input type="checkbox"/> Number of photos: _____</p>	<p>34b. Weapon</p> <p><input type="checkbox"/> Hand <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Head <input type="checkbox"/> Crying</p> <p><input type="checkbox"/> Foot <input type="checkbox"/> Threatening</p> <p><input type="checkbox"/> Knife <input type="checkbox"/> Intoxicated</p> <p><input type="checkbox"/> Gun</p> <p>Placed into evidence <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>34c. Condition of scene</p> <p><input type="checkbox"/> Disorderly</p> <p><input type="checkbox"/> Broken glass</p> <p><input type="checkbox"/> Broken furniture</p> <p><input type="checkbox"/> Holes in walls</p> <p><input type="checkbox"/> Blood on floor/wall</p> <p><input type="checkbox"/> Phone cord yanked out</p> <p><input type="checkbox"/> Phone broken</p> <p><input type="checkbox"/> Other: _____</p>
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35. Location of primary assault:  Living room  Bedroom  Kitchen  Bathroom  Outside  Other \_\_\_\_\_

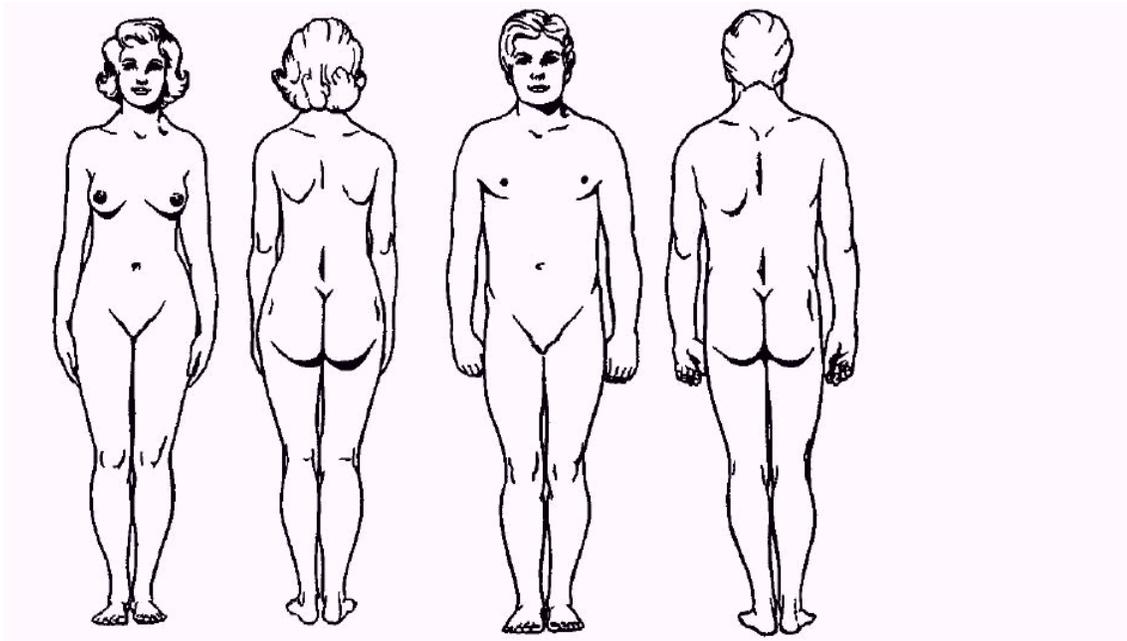
36. Other evidence to support incident:

- Copy of text messages     Copy of E-mail messages     Copy of telephone recordings/messages  
 Copy of medical records from past injuries     In-car video/audio     Other: \_\_\_\_\_

37. Please indicate what type of injury and location on above victim/suspect by the number associated with appropriate below:

37a. Abrasion    37b. Bite    37c. Bruise    37d. Redness    37e. Cuts/Lacerations    37f. Swelling    37g. Tenderness    37h. Soils/debris

## Family Violence Supplement



Female is victim/suspect

Male is victim/suspect

(circle one)

