Alan Behrman & Associates, PC

 2876 Johnson Ferry Rd., Suite 150 Marietta, GA 30062

 1041 Cambridge Square, Suite A Alpharetta, GA 30009

 4855 River Green Pkwy, Suite 330 Duluth, GA 30096

info@alanbehrman.com 770-361-7864 www.alanbehrman.com

**VAWA Evaluation Intake Form**

**\*This Form is Confidential\***

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_**

**Basic Information**

**Full Name (including any other names used):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Sex:** \_\_\_\_\_\_\_\_ **Race/Ethnicity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Place of Birth (Country, State, City):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Marital Status:**

☐ Married ☐ In a relationship ☐ Separated/Divorced ☐ Widowed ☐ Single

**Current Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immigration Information**

**What is your current immigration status in the U.S?**

☐ No legal status

☐ TPS

☐ DACA

☐ Nonimmigrant visa

☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date/age of entry to the U.S.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reasons for relocating to the U.S.:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information about Alleged Abuser**

**Full Name (including any other names used):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to You:**

☐ Spouse/Ex-spouse

☐ Parent

☐ Child

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**U.S. Immigration Status:**

☐ Citizen

☐ Permanent Resident

**Current Living Situation with Alleged Abuser:**

☐ Living together

☐ Not living together

**If Alleged Abuser is/was a spouse, please answer the following questions:**

**Date of Marriage:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship Start and End Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your current marital status?**

☐ Separated

☐ Divorced

☐ Married

☐ Widowed

☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you still in contact?**

☐ Yes

☐ No

**Information About Abuse**

**Please use the table below to list the abuse relevant to your VAWA application:**

|  |  |  |
| --- | --- | --- |
| **Type of Abuse** | **Date(s)** | **Location** |
| ☐ Physical |  |  |
| ☐ Emotional/Psychological |  |  |
| ☐ Economic |  |  |
| ☐ Sexual |  |  |

**Please check all that apply:**

☐ Alleged abuser threatened to report me to immigration authorities or to have me deported.

☐ Alleged abuser threatened to withhold or withdraw immigration benefits or sponsorship.

☐ Alleged abuser used my immigration status to control or manipulate me.

☐ I have been discriminated against or treated unfairly due to my gender.

**Do you have any police reports related to the abuse?**

☐ Yes

☐ No

**Have you been granted any protective orders due to the abuse?**

☐ Yes

☐ No

**Physical and Mental Health Information**

**Were you ever hospitalized for any medical or mental health reasons related to the abuse? (**If yes, please complete the table below).

☐ Yes ☐ No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date/Year** | **Reason** | **Hospital** | **How long?** | **Treatment** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Do you have any medical or mental health conditions? (**If yes, please complete the table below).

☐ Yes ☐ No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date/Year** | **Diagnosis/Condition** | **Provider** | **Clinic/Office** | **Has it gotten worse since/because of the abuse?**  |
|  |  |  |  | ☐ Yes ☐ No |
|  |  |  |  | ☐ Yes ☐ No |
|  |  |  |  | ☐ Yes ☐ No |
|  |  |  |  | ☐ Yes ☐ No |
|  |  |  |  | ☐ Yes ☐ No |
|  |  |  |  | ☐ Yes ☐ No |
|  |  |  |  | ☐ Yes ☐ No |

**Are you able to obtain medical records or letters from doctors, therapists, or other healthcare providers that document your health conditions or treatment?**

☐ Yes ☐ No

**Have you ever talked to a psychiatrist, psychologist, or other mental health professional?**

☐ Yes ☐ No

**Have you ever experienced thoughts of suicide or hurting yourself?**

☐ Yes ☐ No

**Medications**

**Please fill out the table below if you take any medication.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Dosage/Use** | **Reason/For** | **Provider** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Substance Use**

**Do you drink alcohol?**

☐ No

☐ Yes

How much per day/week/month/year? \_\_\_\_\_\_\_\_\_\_\_

**Do you use any non-prescription drugs?**

☐ No

☐ Yes

What kind(s) and how often? \_\_\_\_\_\_\_\_\_\_\_

**Family Information**

**Do you have children?**

☐ Yes ☐ No

(If yes, please list children's dates of birth and names).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Full Name**  | **Date of Birth** | **Sex** | **¿U.S. Citizen or Resident?** | **Name of Biological Parent** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**How would you describe your relationship with your children?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any stepchildren or other dependents?**

☐ No

☐ Yes

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were your parents ever separated or divorced?**

☐ Yes ☐ No

**How would you describe your relationship with your mother?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you describe your relationship with your father?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have siblings?**

☐ No

☐ Yes

 How many brothers? \_\_\_\_\_\_\_\_

 How many sisters? \_\_\_\_\_\_\_\_

Which number are you in birth order? # \_\_\_\_\_\_\_\_

**How would you describe your relationship with your siblings?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Education Information**

**What is your highest level of education?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Where did you attend school/college?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment, Financial, & Social Information**

**Current Employment Status:**

 ☐ Employed or self-employed

 ☐ Unemployed

 ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your occupation?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **How long have you had this occupation?** **\_\_\_\_\_\_\_\_\_\_\_\_**

**Who lives with you in your household?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social support system (family, friends, church/community, etc.)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is the income earner in your household? If more than one provider, please state percentage of income each contributes [e.g., José (husband) 60%, María (wife) 40%]:**

 **Earner 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ = \_\_\_\_\_% Earner 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ = \_\_\_\_\_%**

**Approximately, how much do you pay in household bills monthly?** $ \_\_\_\_\_\_\_\_\_\_\_\_

(This includes rent/mortgage, power, car insurance, phone, groceries, etc.)

**Do you have any outstanding debt(s)?**

☐ No

☐ Yes

How much do you currently owe? $ \_\_\_\_\_\_\_\_\_\_\_\_

**Legal Information**

**Have you ever been arrested?**

☐ No

☐ Yes

Please provide details of the arrest(s) including the date, location, and reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any past or current legal issues (besides your immigration case)?**

☐ No

☐ Yes

Please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe any formal or informal custody arrangements for any minor children (if applicable):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE CHECK ALL THAT APPLY & ***HIGHLIGHT*** THE MAIN PROBLEM:

 **DIFFICULTY WITH: NOW PAST DIFFICULTY WITH: NOW PAST DIFFICULTY WITH: NOW PAST**

 Anxiety People in General Nausea

 Depression Parents Abdominal Distress

 Mood Changes Children Fainting

 Anger or Temper Marriage/Partnership Dizziness

 Panic Friend(s) Diarrhea

 Fears Co-Worker(s) Shortness of Breath

 Irritability Employer Chest Pain

 Concentration Finances Lump in the Throat

 Headaches Legal Problems Sweating

 Loss of Memory Sexual Concerns Heart Palpitations

 Excessive Worry History of Child Abuse Muscle Tension

 Feeling Manic History of Sexual Abuse Pain in joints

 Trusting Others Domestic Violence Allergies

 Communicating Thoughts of Hurting Often Make Careless

 with Others Someone Else Mistakes

 Drugs Hurting Self Fidget Frequently

 Alcohol Thoughts of Suicide Speak Without Thinking

 Caffeine Sleeping Too Much Waiting Your Turn

 Frequent Vomiting Sleeping Too Little Completing Tasks

 Eating Problems Getting to Sleep Paying Attention

 Severe Weight Gain Waking Too Early Easily Distracted by Noises

 Severe Weight Loss Nightmares Hyperactivity

 Blackouts Head Injury Chills or Hot Flashes

**FAMILY HISTORY OF (Check all that apply):**

Drug/Alcohol Problems Physical Abuse Depression

Legal Trouble Sexual Abuse Anxiety

Domestic Violence Hyperactivity Psychiatric Hospitalization

Suicide Learning Disabilities “Nervous Breakdown”

**Any additional information you would like to include: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**Additional Documents**

Throughout the evaluation process, we ask that you provide the following supporting documents so that the therapist can supplement the evaluation used for your immigration case. Please provide these to your therapist in a timely manner to avoid delays, preferably before your last meeting. You can talk to your attorney or paralegal and have them send it to your therapist directly if you prefer.

☐ Form of government-issued photo ID (e.g., driver’s license, passport)

☐ Personal Declaration Letter/Affidavit describing the abuse and how it affected you

☐ Any legal documents related to the abuse (e.g., police reports, restraining orders)

☐ Medical records or letters from healthcare providers documenting any injuries or illnesses related to the abuse (physical and/or mental health)

**Thank you for taking the time to complete this intake form. Your patience and attention are greatly appreciated and will significantly help us in preparing for your evaluation. This information will help ensure a smoother and more efficient process.**