

**SEXUAL ASSAULT HISTORY FORM
NEW MEXICO SEXUAL ASSAULT EVIDENCE KIT (SAEK)**

Patient In-Take

Patient Name: _____ Exam Date: _____

Gender: M F Transgender DOB: _____ LMP: _____

Ethnicity: Native Am. Hispanic African Am. Asian White (non-Hisp.) Mixed Other: _____

Did patient have consensual sex within previous five (5) days? Yes No If yes, vaginal oral anal

Date and time of Assault: _____ Location of Assault: _____

Patient Post-Assault Hygiene Activity:

Urinated: Yes No Unknown Ate/Drank Yes No Unknown

Defecated: Yes No Unknown Showered/Bathed Yes No Unknown

Douched/genital wash Yes No Unknown Brushed Teeth/Gargled Yes No Unknown

Suspect Information:

Suspect: Family Member Stranger Acquaintance Intimate/Ex-Intimate Partner Other: _____

Suspect Gender: Male Female Number of suspects: _____ Suspect Age(s): _____
(If more than one suspect, write additional information on the back of the page)

Use of force, coercion or weapon? Yes No Unknown If yes, describe: _____

Patient's Description of Assault: _____

Clothing Information

- Clothes not available (washed or lost). Patient declined to submit all, or part, of clothing into evidence.
- Patient *wearing* clothes worn during assault collected for SAEK.
- Patient *brought* clothing worn during assault collected for SAEK.
- Clothing worn at time of assault collected by law enforcement.

Identification and description of clothing collected: Bra _____

Shirt/Blouse _____ Underwear _____

Skirt/Dress _____ Pants _____

Socks/Shoes (include #) _____ Jacket/Coat _____

Other: _____

SEXUAL ASSAULT FORM, Continued
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Summary of Acts Described by Patient

Penetration of Female Genitalia:	Yes	No	Attempted	Unsure	Comments:
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign object	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Penetration of Anus:	Yes	No	Attempted	Unsure	
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign object	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Copulation of Genitals:	Yes	No	Attempted	Unsure	
Suspect to patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patient to suspect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Copulation of Anus:	Yes	No	Attempted	Unsure	
Suspect to patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patient to suspect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Masturbation:	Yes	No	Attempted	Unsure	
Suspect to patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patient to suspect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suspect to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patient to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did Ejaculation Occur:	Yes	No	Attempted	Unsure	
Inside body orifice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Outside body orifice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Specify Location:	_____				

Was a condom used? Yes No Unknown

Did patient injure suspect: Yes No Attempted If yes, describe: _____

Environmental Debris: Yes No If yes, describe: _____

Fingernail Evidence: Yes No If yes, describe: _____

Miscellaneous Evidence Yes No If yes, describe each type/location of miscellaneous evidence collected: _____

Urine collected for suspected drug facilitated assault: Yes No

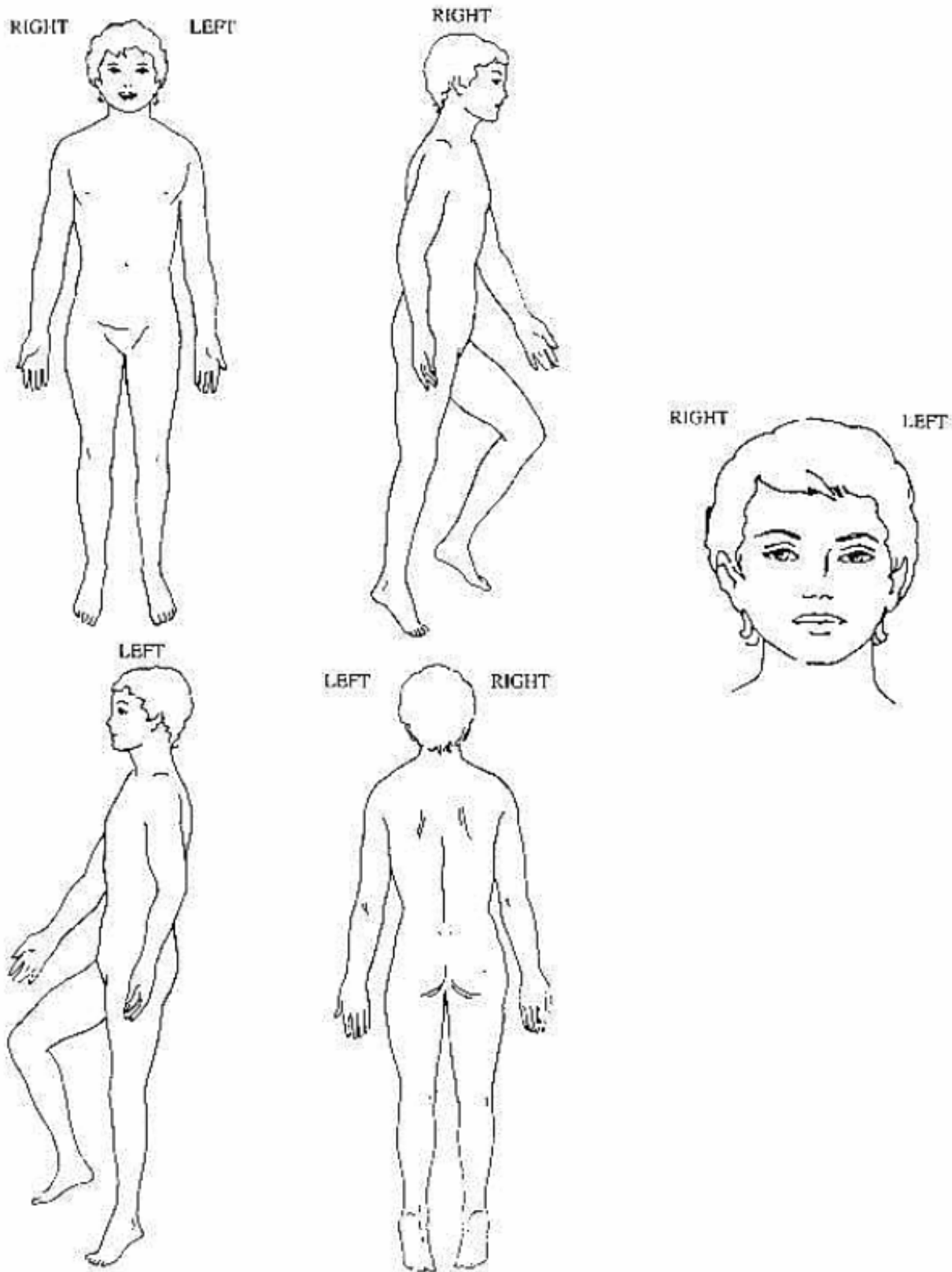
Photographs taken: Yes No If yes, estimate number of photographs: _____

Examiner's Name: _____

Date/Time: _____

SEXUAL ASSAULT FORM, Continued
NEW MEXICO SEXUAL ASSAULT EVIDENCE KIT (SAEK)

BODY MAP: Use this body map to note physical assessment of patient. Note location of injuries. Describe injuries, including size, shape, color, presence of swelling, tenderness, redness, tears or abrasions, etc.



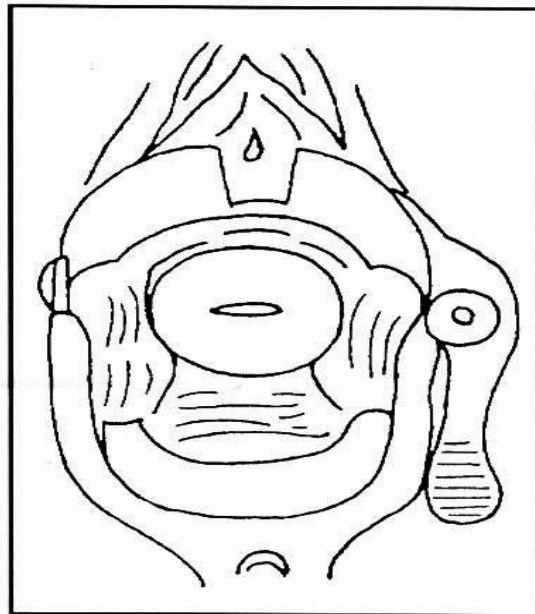
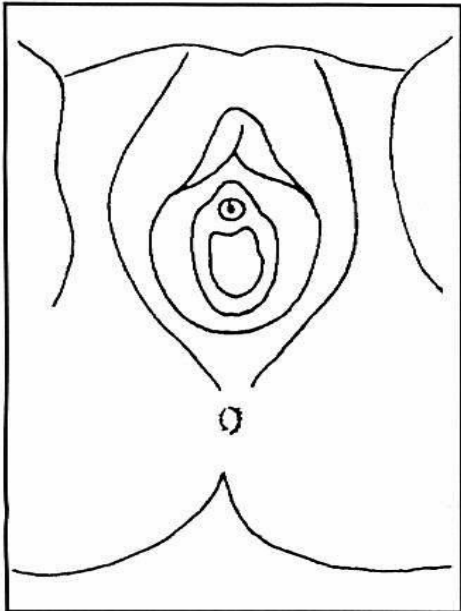
Examiner's Name: _____

Date/Time: _____

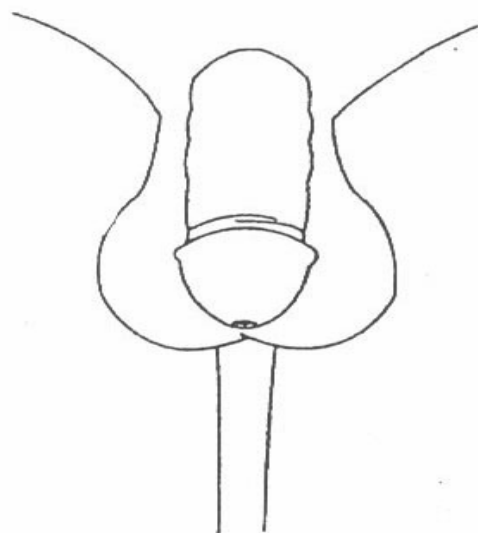
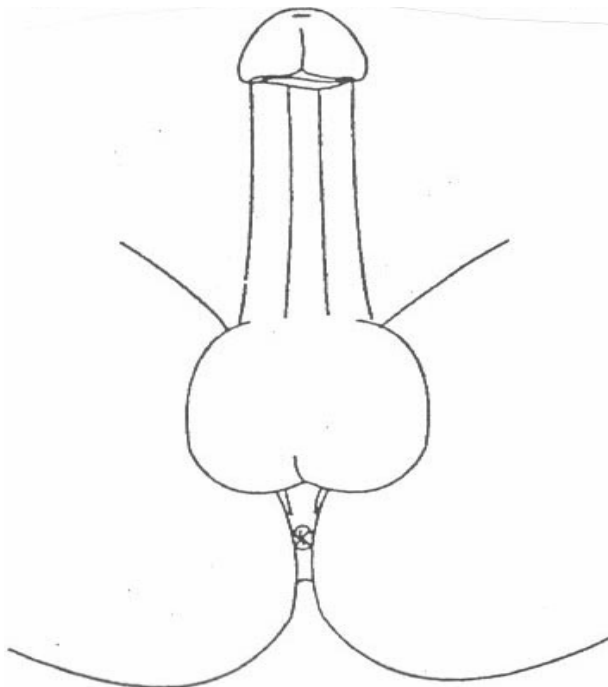
SEXUAL ASSAULT FORM, Continued
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GENITAL MAP: Use the appropriate genital map to note physical assessment of patient's genitalia. Note location of injuries. Describe injuries, including size, shape, color, presence of swelling, tenderness, redness, tears, abrasions, etc.

FEMALE



MALE



Place a copy of this completed 4-page form INTO the large, white 10" x 15" envelope of the Sexual Assault Evidence Kit (SAEK).

Examiner's Name: _____

Date/Time: _____