

Preschool/School Age

Polinsky Children's Center
Safety Violence Questionnaire
For Preschool and School Age Children

(1) Do you use a helmet when... YES/NO
Bike riding?
Skateboarding?
Rollerblading?

(2) When riding in a car do you use a seatbelt? YES/NO

(3) Do you know anybody who uses... YES/NO
Alcohol?
Drugs?

WHO? YES/NO
Parent
Relative
Brother/sister
Neighbor
Friend
Other

(4) Do you know anybody who has a... YES/NO
Gun?
Knife/other weapon

WHO? YES/NO
Parent
Relative
Brother/Sister
Neighbor
Friend
Other

If yes, is it kept in your house?

(5) How are you punished at your house? YES/NO
Not Punished
Yelling
Time/out Grounding
Hitting
Other



With what?	YES/NO
Hand	<input type="checkbox"/> <input type="checkbox"/>
Foot	<input type="checkbox"/> <input type="checkbox"/>
Belt	<input type="checkbox"/> <input type="checkbox"/>
Kitchen Utensil	<input type="checkbox"/> <input type="checkbox"/>
Cord	<input type="checkbox"/> <input type="checkbox"/>
Hanger	<input type="checkbox"/> <input type="checkbox"/>
Shoe	<input type="checkbox"/> <input type="checkbox"/>
Other	<input type="checkbox"/> <input type="checkbox"/>

(6) Does anyone in your house call you names?

(7) Have the police ever been to your house?

If yes, WHY?

Drugs	<input type="checkbox"/> <input type="checkbox"/>
Fighting in your house	<input type="checkbox"/> <input type="checkbox"/>
To take you away	<input type="checkbox"/> <input type="checkbox"/>
To bring your mom/dad to jail	<input type="checkbox"/> <input type="checkbox"/>
To bring someone else to jail	<input type="checkbox"/> <input type="checkbox"/>
Don't know why	<input type="checkbox"/> <input type="checkbox"/>

(8) Do any adults in your household hit each other YES/NO

If yes, **WHO** gets hit?

	YES/NO
Mom	<input type="checkbox"/> <input type="checkbox"/>
Dad	<input type="checkbox"/> <input type="checkbox"/>
Stepmother	<input type="checkbox"/> <input type="checkbox"/>
Stepfather	<input type="checkbox"/> <input type="checkbox"/>
Mom's boyfriend	<input type="checkbox"/> <input type="checkbox"/>
Dad's girlfriend	<input type="checkbox"/> <input type="checkbox"/>
Other _____	

By **WHOM?** YES/NO

Mom	<input type="checkbox"/> <input type="checkbox"/>
Dad	<input type="checkbox"/> <input type="checkbox"/>
Stepmother	<input type="checkbox"/> <input type="checkbox"/>
Stepfather	<input type="checkbox"/> <input type="checkbox"/>
Mom's boyfriend	<input type="checkbox"/> <input type="checkbox"/>
Dad's girlfriend	<input type="checkbox"/> <input type="checkbox"/>
Other _____	

Does anyone get hurt?
Did you witness this?

(9) Has anyone ever touched you in your privates? YES/NO

If yes, **WHO?**

	YES/NO
Mom	<input type="checkbox"/> <input type="checkbox"/>
Dad	<input type="checkbox"/> <input type="checkbox"/>
Stepmother	<input type="checkbox"/> <input type="checkbox"/>
Stepfather	<input type="checkbox"/> <input type="checkbox"/>
Mom's boyfriend	<input type="checkbox"/> <input type="checkbox"/>
Dad's girlfriend	<input type="checkbox"/> <input type="checkbox"/>
Other _____	

