Abuse Assessment Screen-Disability
(AAS-D)

These questions are designed to open the door for you to discuss with your health care provider, counselor, or other person you trust about problems you may be having with abuse or violent relationships. We encourage you to take advantage of this opportunity. If, however, you live in one of the states with mandatory reporting of violence against people with disabilities (e.g. Texas), please be aware that the person to whom you disclose the abuse may be required by law to report it to the appropriate authorities who, in turn, may investigate your situation.

1. Within the last year, have you been hit, slapped, kicked, pushed, shoved or otherwise physically hurt by someone?

Yes ____ No____

If Yes, who? (Circle all that apply)

* Intimate Partner * Care Provider * Health Professional * Family Member * Other

Please describe: ___________________________________________________
_________________________________________________________________

2. Within the last year, has anyone forced you to have sexual activities?

Yes ____ No____

If Yes, who? (Circle all that apply)

* Intimate Partner * Care Provider * Health Professional * Family Member * Other

Please describe: ___________________________________________________
_________________________________________________________________

3. Within the last year, has anyone prevented you from using a wheelchair, cane, respirator, or other assistive devices?

Yes ____ No____

If Yes, who? (Circle all that apply)
* Intimate Partner * Care Provider * Health Professional * Family Member * Other

Please describe: ________________________________________________________________
____________________________________________________________________________

4. Within the last year, has anyone you depend on refused to help you with an important personal need, such as taking your medicine, getting to the bathroom, getting out of bed, bathing, getting dressed, or getting food or drink?

Yes ____ No____

If Yes, who? (Circle all that apply)

* Intimate Partner * Care Provider * Health Professional * Family Member * Other

Please describe: ________________________________________________________________
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