1) Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals?

Yes No

2) Has anyone prevented you from getting clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?

Yes No

3) Have you been upset because someone talked to you in a way which made you feel shamed or threatened?

Yes No

4) Has anyone tried to force you to sign papers or to use your money against your will?

Yes No

5) Has anyone made you afraid, touched you in ways which you did not want, or hurt you physically?

Yes No

Print Patient Name _____ Date _____

Provider Signature _____ Date _____