Data Collection Form:

Initial Information	
Date:	
Time:	
Child's Name:	
Date of Birth:	
Sex:	
Hospital Number:	
Accompanying caretaker's name and relationship:	
Names and relationships of other relevant adults (i.e parents, siblings):	
Family physician:	

Initial History from Accompanying Adult (out of earshot of child if possible)	
Who is the alleged perpetrator?	
What is the relationship of perpetrator to child?	
When and where did the contact happen? (first, last)	
When was last possible contact?	
What contact occurred?	
Other history of abuse or exposure to suspected sex offenders?	
History of genitorectal problems? (bleeding, discharge, constipation)	
History of accidental genitorectal injury?	
History of behavior problems? Especially sexual behavior?	
For Adolescents	
Has consensual sex occurred? If so, when was last time?	
Have menses occurred? Specify…	
Have tampons been used?	

History from child (out of earshot of parent if possible)	
What happened?	
When?	
Who was involved?	
Where?	
How many times?	
What body parts were involved?	
Did ejaculation occur?	
Was there pain or bleeding?	
Were there threats or secrets?	

Exam Documentation	
Exact location of injuries –size, shape, color, age	
Who is in the room during exam	
Position of child during exam	
Equipment used (magnification/illumination techniques	
Appearance of perineum, vulva, labia, introitus, hymen, urethra, vagina, glans, penile shaft, scrotum, testes, forchette and fossa, anorectal area	
If a finding is noted on the hymen, specify exactly where it is using the numbers on the clock (i.e hymenal defect at seven o'clock	
Level of anxiety during history and physical	
Any bleeding or discharge	
Any acute abnormalities	