

Strangulation Quick Reference Guide

- ☐ How and where was the victim strangled?
- ☐ One Hand (R or L) Two hands, Forearm (R or L), Knee/Foot, Ligature (Describe)
- ☐ How long? _____ seconds _____ minutes
- ☐ Was the victim smothered?
- ☐ From 1 to 10, how hard was the suspect's grip? (Low) 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (high)
- ☐ From 1 to 10, how painful was it? (Low) 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (high)
Multiple attempts: _____ Multiple methods: _____
- ☐ Was the victim shaken simultaneously while being strangled? Straddled?
- ☐ Held against wall?
- ☐ Was the victim's head being pounded against wall, floor or ground?
- ☐ What did the victim think was going to happen?
- ☐ What caused the strangulation to stop?
- ☐ Any prior incidents of strangulation? Prior domestic violence? Prior threats?

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Document All Findings in an Appropriate Report or Chart

Face	Eyes & Eyelids	Nose	Ears	Mouth
<input type="checkbox"/> Red/flushed <input type="checkbox"/> Petechiae <input type="checkbox"/> Scratches	<input type="checkbox"/> Petechiae R/L eye <input type="checkbox"/> Petechiae R/L lid <input type="checkbox"/> Bloody conjunctiva	<input type="checkbox"/> Nosebleed <input type="checkbox"/> Deformity <input type="checkbox"/> Petechiae (in or on)	<input type="checkbox"/> Petechiae (in or on) <input type="checkbox"/> Bleeding from ear canal	<input type="checkbox"/> Bruising <input type="checkbox"/> Swollen tongue/lips <input type="checkbox"/> Cuts/abrasions
Under Chin	Neck	Shoulders	Chest	Head
<input type="checkbox"/> Redness <input type="checkbox"/> Scratches <input type="checkbox"/> Bruising <input type="checkbox"/> Abrasions	<input type="checkbox"/> Redness <input type="checkbox"/> Scratches <input type="checkbox"/> Bruising <input type="checkbox"/> Abrasions <input type="checkbox"/> Edema (swelling) <input type="checkbox"/> Fingernail impressions <input type="checkbox"/> Ligature marks	<input type="checkbox"/> Redness <input type="checkbox"/> Scratches <input type="checkbox"/> Bruising <input type="checkbox"/> Abrasions	<input type="checkbox"/> Redness <input type="checkbox"/> Scratches <input type="checkbox"/> Bruising <input type="checkbox"/> Abrasions	<input type="checkbox"/> Petechiae <input type="checkbox"/> Missing hair <input type="checkbox"/> Edema <input type="checkbox"/> Fractures <input type="checkbox"/> Concussion
Breathing Changes	Voice Changes	Swallowing Changes	Behavioral Changes	Other
<input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Hyperventilation <input type="checkbox"/> Unable to breathe	<input type="checkbox"/> Raspy Voice <input type="checkbox"/> Hoarse Voice <input type="checkbox"/> Coughing <input type="checkbox"/> Unable to or difficulty speaking	<input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Painful swallowing <input type="checkbox"/> Neck Pain <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Drooling	<input type="checkbox"/> Agitation <input type="checkbox"/> Amnesia <input type="checkbox"/> PTSD <input type="checkbox"/> Hallucinations <input type="checkbox"/> Combativeness	<input type="checkbox"/> Dizzy <input type="checkbox"/> Headaches <input type="checkbox"/> Fainted <input type="checkbox"/> Urination <input type="checkbox"/> Defecation