

Domestic Violence Restraining Order Packet

Your appointment with the legal department is scheduled for:

Date:_____ **Time:**_____

Please finish this packet before the day of your appointment. If your packet is unfinished, we will schedule you for a new date and time. If you need help with filling out the packet, please come to your appointment at least 30 minutes early. You can also call us at (209) 725-7900.

If you are more than 15 minutes late to your appointment, you will need to reschedule.

Please be aware that it can take up to two hours to work on your order. We know that our clients may have children; but because of how long it takes, we ask that you try to find other kinds of childcare to make this easy on you. You may bring them with you if you cannot find other childcare.

Valley Crisis Center will finish the forms to submit your temporary order. Once we take the forms to court, we have no control of how long it takes to get them signed by the judge and returned to us.

Once we do get the temporary order back from the court we will package it and call you to pick up your copies. When you do come in to pick up your order, someone will explain what the judge ordered, what you need to do next, and your court dates.

Please complete as much as possible.

Client Information (Name of Person Seeking Protection):

Name:

Address:

City: _____ State: _____

Zip Code: _____

Date of Birth: ____/____/____ Age: ____ Race: _____

Hair Color: _____ Eye Color: _____

Weight: _____ Height: _____

Gender: _____

Telephone Number: _____

Cell Phone Number: _____

Are You Requesting To Use Our Confidential Address? Yes No

What Is Your Relationship To The Other Party?

We are Married Used to be Married We Live Together

Used to Live Together We are Dating Used to Date

We are the Parents of Minor Children

Other Party Information (Person you are Seeking Protection from):

Name:

Address:

City: _____ State: _____

Zip Code: _____

Date of Birth: ____/____/____ Age: ____ Race: _____

Hair Color: _____ Eye Color: _____

Weight: _____ Height: _____ Gender: _____

Driver's License Number: _____

State Issued In: _____

Telephone Number: _____

Cell Phone Number: _____

Scars, marks, or tattoos:

Other Names Used by the Other Party:

Is the Other Party Employed? Yes No If yes, please complete:

Employer:

Business Address:

City: _____ State: _____

Zip Code: _____

Telephone Number: _____

Occupation/Job: _____

Work Hours:

Does The Other Party Have Access To Guns? Yes No

If yes, what kind, how many and where are they kept?

Children Information (Minor Children That Are Both Yours and The Other Party's):

Name	Age	Date of Birth	Gender	Lives With You	Ethnicity
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you want other people who live with you protected?

Name	Age	Date of Birth	Gender	Lives With You	Ethnicity
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Do You Want To Change or Include Child Custody/Visitation Orders?

Change: Yes No **Include:** Yes No

Children Address for the Last 5 Years?

(You Only Have to Fill Out if You Are Requesting Custody)

City, State	Child Lives With	Dates Lived There
_____	<input type="checkbox"/> Mom <input type="checkbox"/> Dad	_____ To Present _____
_____	<input type="checkbox"/> Mom <input type="checkbox"/> Dad	_____ To _____
_____	<input type="checkbox"/> Mom <input type="checkbox"/> Dad	_____ To _____
_____	<input type="checkbox"/> Mom <input type="checkbox"/> Dad	_____ To _____

Have You Been Involved In Any Other Court Cases: Yes No Unsure

If yes, what type of case?

- Child Custody Divorce Criminal Domestic Violence Juvenile
- Civil Harassment

If So, What County, Year Filed And Case Number:

County: _____ Case Number: _____

Year: _____

Do You Have A Current Emergency Protective Order? Yes No

This Is an Order Issued By Police Only

Case Number: _____ Date of Order: _____

Expiration Date: _____

Do You Have A Criminal Protective Order In Place At This Time?

Yes No Unsure

Case Number: _____ Date of Order: _____

Expiration Date: _____

Are You Requesting a Move Out Order? Yes No

If you both are currently living at the same address and would like the Other Party to move out.

Is the Address the Same as Above? Yes No If No, What is the Address?

Address:

City: _____ State: _____

Zip Code: _____

Do You Want Temporary Control/Use Of Property? Yes No

Please list any houses, cars, or personal belongings you want control of:

Would You Like To Have Any Animals Protected In This Order? Yes No

Please List:

Would You Like Rights To Mobile Devices And Wireless Phone Accounts?

Yes No (if yes please list the type of phone(s) and number(s) below)

Phone Number(s):

Make/Model/Number:

_____ (_____) _____ - _____

Make/Model/Number:

_____ (_____) _____ - _____

Make/Model/Number:

_____ (_____) _____ - _____

Make/Model/Number:

_____ (_____) _____ - _____

**Are There Any Pictures, Emails Or Text Messages You Would Like To
Include? Yes No**

A Domestic Violence Restraining Order Protects People From Abuse.

It is important that you complete the next three pages with as much detail and as accurate as possible from the incidents only. If you need additional room, please use the back of the packet.

Most Recent Incident of Abuse

Date of Most Recent Abuse: _____

Who Was There? _____

What did the other party do or say that made you afraid?

Describe Any Injuries: _____

Did The Police Come? Yes No

If Yes, Did You Receive An Emergency Protective Order? Yes No

Case Number: _____ Date of Order: _____

Expiration Date: _____

Is The Other Party in Jail or Prison? Yes No If Yes, Where?

Sandy Mush Main Jail Other: _____

Second Most Recent Incident of Abuse

Date of Second Most Recent Abuse: _____

Who Was There? _____

What did the other party do or say that made you afraid?

Describe Any Injuries:

Did The Police Come? Yes No

If Yes, Did You Receive An Emergency Protective Order? Yes No

Case Number: _____ Date of Order: _____

Expiration Date: _____

Additional Information:

Has the Other Party Ever Done the Following?

(Check all that they have done to you)

- | | | |
|---|--|---|
| <input type="checkbox"/> Slapped | <input type="checkbox"/> Twisted Arm | <input type="checkbox"/> Criticizes How You Look |
| <input type="checkbox"/> Tried to Smother | <input type="checkbox"/> Ripped Clothing | <input type="checkbox"/> Threatens to Take Kids |
| <input type="checkbox"/> Shake | <input type="checkbox"/> Forced to Have Sex | <input type="checkbox"/> Tracks Your Time |
| <input type="checkbox"/> Bang Head | <input type="checkbox"/> Forced to
Have/Perform Oral Sex | <input type="checkbox"/> Criticizes Your
Intelligence |
| <input type="checkbox"/> Push to the Ground | <input type="checkbox"/> Forced to
Have/Perform Anal
Sex | <input type="checkbox"/> Criticizes Your Work |
| <input type="checkbox"/> Bite | <input type="checkbox"/> Spit in Face | <input type="checkbox"/> Criticizes Your
Housework |
| <input type="checkbox"/> Grabbed | <input type="checkbox"/> Pulled Hair | <input type="checkbox"/> Prevents you from seeing
Family |
| <input type="checkbox"/> Squeezed | <input type="checkbox"/> Wrestled | <input type="checkbox"/> Criticizes Parenting Skills |
| <input type="checkbox"/> Kicked | <input type="checkbox"/> Pinned Down | <input type="checkbox"/> Prevents You From
Activities |
| <input type="checkbox"/> Scratch | <input type="checkbox"/> Tied Up | <input type="checkbox"/> Threatens to Kill You |
| <input type="checkbox"/> Abused the
Children | <input type="checkbox"/> Choked | <input type="checkbox"/> Insults in Front of Others |
| <input type="checkbox"/> Hit with Objects | <input type="checkbox"/> Shoved | <input type="checkbox"/> Thrown Things |
| <input type="checkbox"/> Burned Things | <input type="checkbox"/> Punched | <input type="checkbox"/> Damaged the Car |
| <input type="checkbox"/> Broken Things | <input type="checkbox"/> Hurt Pets | |

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Injuries You Have Gotten from The Other Party:

(Check all the injuries you may have gotten from the Other Party)

- | | | |
|---|---|--|
| <input type="checkbox"/> Bruises | <input type="checkbox"/> Cuts Needing Stitches | <input type="checkbox"/> Sought Medical Care |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Sprains | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Back Injuries | <input type="checkbox"/> Burns | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Cuts | <input type="checkbox"/> Scratches | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Black Eyes | <input type="checkbox"/> Injuries from Sex | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shaking | <input type="checkbox"/> Crying | <input type="checkbox"/> Insomnia/Lack of Sleep |

Does The Other Party Call You Names?

(Please list all Names The Other Party Calls You)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____