(INTAKE/SCREENING FORM)

INTAKE DATE: ___ /___ / ______ *(mm/dd/yyyy)*

☐☐☐☐☐☐☐☐☐☐☐☐
(URN)

CLIENT INFORMATION

Client Name: ______________________________ *(First name)* ____________________________ *(Last Name)*

Date of Birth: ______ / ______ / ______ *(mm/dd/yyyy)* Social security number:____________________

Highest Educational Level:

☐ Less than 9th grade ☐ 9th-12th grade (no diploma) ☐ High School graduate
☐ Some college, no degree ☐ Associate degree ☐ Bachelor's degree
☐ Master's degree ☐ Professional degree ☐ Doctorate degree
☐ Military ☐ Technical / vocational training

Primary Language:

☐ English ☐ Spanish ☐ French ☐ American Sign Language ☐ Vietnamese
☐ German ☐ Italian ☐ Korean ☐ African Languages

☐ ***Client received copy of informed consent***

DEMOGRAPHICS (Please check all that apply)

Race	Hispanic	Non-Hispanic	Unknown
White			
Black/African American			
Asian			
Native American/Alaskan			
Pacific Islander/Native Hawaiian			
Other			
Refuse to Respond			

Gender:

☐ Male ☐ Transgender Female-to-Male ☐ Unknown
☐ Female ☐ Transgender Male-to-Female ☐ Refuse to Respond
☐ Transgender Unknown

Sexual Orientation:
Do you consider yourself to be…?

☐ Heterosexual/Straight ☐ Gay/Lesbian ☐ Bisexual

☐ Other: _______________ ☐ Respondent does not understand responses

☐ Refuse to Respond

Employee's Name: ___________________________ (First) ___________________________ (Last)

(INTAKE/SCREENING FORM)

CLIENT ENROLLMENT STATUS *(Please check appropriated box)*

☐ New ARTAS Client ☐ Lost to Care

RESIDENCY INFORMATION

Street Address: ____

City: ______________________________ Zip Code: _____________ State: ________

Do you receive mail here? ☐ Yes ☐ No Email Address: ______________________

Where can we send mail if needed? ____________________________________

Phone #: (____) - ________ - ________ Cell Phone #: (____) - ________ - ________

Where do you usually hang out? ______________________________________

Can we contact you at work? ☐ Yes ☐ No ☐ N/A Work #: (_____) - ________ - ________

ALTERNATIVE/EMERGENCY CONTACT 1 *(such as family, friend, case manager, etc.)*

☐ Refused

Name: _____________ *(First name)* ______________*(Last Name)* Relationship: ________________

Street Address: ____

City: ______________________________ Zip Code: _____________ State: ________

Phone #:(____)-____-____ Cell #:(____)- ____ - ____ Email Address: ______________________

Is this contact aware of your HIV status? ☐ Yes ☐ No

Preferred way to contact: ☐ Phone ☐ Cell ☐ Email

If preferred way to contact is by calling the alternative/emergency contact's phone or cell phone:

The best time to contact him/her is between ______ to ______ (am) or _______ to _______ (pm)

Comments: ____
____

Employee’s Name: ________________________ (First)________________________ (Last)

(INTAKE/SCREENING FORM)

ALTERNATIVE/EMERGENCY CONTACT 2 *(such as family, friend, case manager, etc.)*

☐ Refused

Name: _______________ *(First name)* ________________*(Last Name)* Relationship: __________________

Street Address: ____

City: _____________________________________ Zip Code: ________________ State: __________

Phone #:(____)-____-____ Cell #:(____)- ____ - ____ Email Address: ___________________________

Is this contact aware of your HIV status? ☐ Yes ☐ No

Preferred way to contact: ☐ Phone ☐ Cell ☐ Email

If preferred way to contact is by calling the alternative/emergency contact's phone or cell phone:

The best time to contact him/her is between ______ to ______ (am) or _______ to _______ (pm)

Comments: ____

____

HIV STATUS (*Please check appropriate boxes)*

☐ HIV-positive, not AIDS ☐ HIV-positive, AIDS status unknown ☐ HIV-positive, AIDS

How was status assessed:

☐ Status self-reported ☐ HIV Epidemiology/Surveillance ☐ Previous Medical Records

DIAGNOSIS DATES

HIV: _____ / _____ / _______ *(mm/dd/yyyy)* ☐ Estimated

AIDS (if applicable): _____ / _____ / _______ *(mm/dd/yyyy)* ☐ Estimated

HIV RISK FACTORS (CURRENT) *Check all that apply*

☐ Men Who Have Sex with Men
☐ Injection Drug User
☐ Hemophilia/Coagulation Disorder
☐ Heterosexual Contact
☐ Perinatal Transmission
☐ Unknown/Unreported
☐ Transfusion of Blood or Blood Components
☐ Other _

Employee's Name: _________________________ (First)_________________________ (Last)

(INTAKE/SCREENING FORM)

QUALITY OF LIFE

Would you say that in general your health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Refused to answer ☐ Don't know

CLIENT NEEDS

I am going to read a list of services and resources. Please indicate to me which ones you currently need.
(Please indicate which of these services is most urgent for the client now)

Currently Need	*Most Urgent (Check only one)*	
☐	☐	Drug and Alcohol abuse treatment
☐	☐	Housing or Shelter
☐	☐	Food or other subsistence needs
☐	☐	Dental Services
☐	☐	HIV-related Medical Services
☐	☐	Non-HIV related Medical Services
☐	☐	Pharmacy or Medication Services (For HIV or non HIV reasons)
☐	☐	Mental Health Services (inpatient or outpatient)
☐	☐	Other: ____

BARRIERS TO CARE

Often people with HIV face barriers to getting HIV care. What factors make it hard for you to get care?
(Let the client answer. Do not read the following options; only fill the boxes based on the client's answers)

☐ Lack of money	☐ Fear	☐ Lack of supported services
☐ Homelessness	☐ Stigma	☐ Transportation
☐ Immigration	☐ Denial	☐ Location of care
☐ Incarceration	☐ Distrust of Medical System	☐ HIV testing issues
☐ Drug use	☐ Lack of perceived need	☐ Competing priorities
☐ No barriers		

Other: ____

Employee's Name: ________________________ (First) ________________________ (Last)

(INTAKE/SCREENING FORM)

STIGMA

Now I will read you some statements, please tell me how often you have felt this way.

Not at all	Rarely	Sometimes	Often	
☐	☐	☐	☐	I've felt that people avoided me because I have HIV
☐	☐	☐	☐	I've feared I would lose friends if they learned about my HIV
☐	☐	☐	☐	I've thought other people were uncomfortable being with me because of my HIV
☐	☐	☐	☐	I've avoided getting treatment because someone might find out about my HIV

CLIENT ENGAGEMENT

How did ALCM first engage client: *(Choose one)*

- ☐ Street outreach
- ☐ Social media
- ☐ Peer outreach (other than street outreach) Site: ______________________
- ☐ Partner Services/CRCS
- ☐ CBO Referral
- ☐ Other (Specify) ___________________________

____ **Zip** Code: ____________________

(***i.e. Health Fair, ER dept, etc.)***

Now I'm going to ask you some questions about any drugs you may be using. Please answer honestly.

SUBSTANCE USE AND MENTAL ILLNESS

Do you smoke? ☐ Yes ☐ No ☐ Refused to answer

If yes how much do you smoke a day? (# of cigarettes) _______________________________________

Do you drink alcohol? ☐ Yes ☐ No ☐ Refused to answer

If yes, how much do you drink a day? (12 oz beer, 8-9 oz malt liquor, 5 oz wine, 1.5 oz liquor)

____

If yes, how much do you drink a week? ____________________________________

Do you use drugs (other than medications prescribed by a medical professional)?

☐ Yes ☐ No ☐ Refused to answer

Employee's Name: ___________________________ (First) ___________________________ (Last)

(INTAKE/SCREENING FORM)

SUBSTANCE USE (continued)

If yes what drugs (type/name) do you use?
____

If yes, how often do you use these drugs? ____

____

____

Would you like to reduce or quit (any of the above)? ☐ Yes ☐ No

Have you ever tried to reduce or quit? ☐ Yes ☐ No

Have you ever entered any treatment program(s)? ☐ Yes ☐ No

*If the client says that he or she would like to reduce or quit any of these substance use behaviors, refer him/her to the appropriate person for an additional consultation. If you feel that the client is displaying dangerous substance use behaviors, report it to your supervisor and refer him/her for additional consultation.

Now I'm going to ask you a few questions about how you have been feeling mentally and emotionally. Please answer honestly.

SELF-REPORTED SYMPTOMS

Most people have periods when they are not at their best emotionally. During the PAST 30 DAYS, how often did you feel:

	1 – All of the time	2 – Most of the time	3 – Some of the time	4 - A little of the time	5 – None of the time	R – Refused	D – Don't know
Nervous?							
Hopeless?							
Restless or fidgety?							
So sad or depressed that nothing could cheer you up?							
That everything was an effort?							
Down on yourself, no good, or worthless?							

Have you ever been diagnosed with an emotional disorder, such as anxiety, schizophrenia, post-traumatic stress disorder, etc.)?
☐ Yes ☐ No ☐ Don't know ☐ Refused to answer

Are you receiving treatment for an emotional disorder?
☐ Yes ☐ No ☐ Don't know ☐ Refused to answer

Employee's Name: ________________________ (First) ________________________ (Last)

MENTAL ILLNESS (Continued)

Type of treatment: ____

____

Have you ever been diagnosed with a mental disorder, such as depression, anxiety, schizophrenia, post-traumatic stress disorder, etc)? ☐ Yes ☐ No ☐ Don't know ☐ Refused to answer

Are you receiving treatment for a mental disorder, such as depression, anxiety, schizophrenia, post-traumatic stress disorder, etc)? ☐ Yes ☐ No ☐ Don't know ☐ Refused to answer

Type of treatment: ____

____

*If the client's answers to the mental illness raise a red flag, alert a supervisor and refer the client for the appropriate consultation. If you think the person might harm him/herself – do not leave the client alone. Contact your supervisor.

Employee's Name: __________________________ (First) __________________________ (Last)