Georgia Department of Public Health

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

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)*

☐ Newly Diagnosed Client ☐ Previously Diagnosed ☐ 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)

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

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: _____
		_____

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

(INTAKE/SCREENING FORM)

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: _____

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

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

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

☐ Yes ☐ No ☐ Refused to answer

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

_____

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

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

*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

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

MENTAL ILLNESS

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

*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)