HEALTH AND HUMAN SERVICES

Client Name: _____ DOB: _____

PRESCREENING AND RISK QUESTIONNAIRE

You can get this form in different ways, like large print or other languages.
If you need help with this form, just ask us.

Please briefly explain why you are seeking services currently:

What do you hope to get out of treatment?

Are you required to seek services by the court?	◯ Yes	◯ No		
Do you have a court case pending?	◯ Yes	◯ No		
Have you ever been convicted of a person-to-person crime?	◯ Yes	◯ No		
Are you currently having suicidal or homicidal thoughts or actions?	◯ Yes	◯ No		
Do you have a history of suicidal or homicidal thoughts or actions?	◯ Yes	◯ No		
Do you worry about your safety?	◯ Yes	◯ No		
Are you in active detox/withdrawal?	◯ Yes	◯ No		
Have you ever used IV drugs?	◯ Yes	◯ No		
Have you used IV drugs in the past 30 days?	◯ Yes	◯ No	◯ N/A	
Have you used alcohol or drugs in the past 90 days?	◯ Yes	◯ No		
Are you pregnant?	◯ Yes	◯ No	◯ N/A	◯ Unknown
If yes, are you getting prenatal care?	◯ Yes	◯ No		

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HEALTH HISTORY QUESTIONNAIRE

This form is available in alternative formats including large print, other Languages and oral presentation. Let us know if you need any assistance completing this form

PHYSICIAN HISTORY AND INFORMATION

When was your last physical exam?

When was your last Dental visit?

Do you have a Primary Care physician (PCP), Clinic or Organization? ☐No ☐Yes *(list below)*

List any current Medical and Dental Providers

Name, Address & Phone number	Reason	Date of Last visit

HEALTH INFORMATION

Are there health issues that need immediate attention? ☐No ☐Yes, *(Describe below)*

Have you had any accidents, injuries, illnesses that have impacted health/functioning: ☐Yes ☐No

Please list approximate dates for major accidents/injuries, illnesses and mental health hospitalizations

Do you have any allergies? ☐No ☐Yes, *(Describe below)*

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HEALTH CONDITIONS

Select any conditions below that apply to your history or current health

☐Hepatitis	☐Infectious Diseases	☐Surgery	☐Chronic Fatigue
☐HIV Positive	☐Blackouts/Dizzy Spells	☐Head Injuries	☐Back Problems
☐Liver Problems	☐High Blood Pressure	☐Arthritis	☐Menstrual/PMS
☐Kidney Problems	☐Heart Problems	☐Muscle or Joint Problems	☐Miscarriages
☐Tuberculosis	☐Stroke/Circulation Problems	☐Chronic Pain	☐Abortion
☐Cancer	☐Thyroid Condition	☐Poor Nutrition	☐Pregnancy
☐Diabetes	☐Severe Headaches/Migraines	☐Eating Disorder	☐Anemia
☐Seizures/Epilepsy	☐Respiratory	☐Stomach Problems	☐Tobacco Use
☐Skin Infections/Conditions	☐Hospitalization	☐Sleep Problems	☐Bedwetting/Day-time soiling

Other:

Explain any of the checked above that you have experienced within the last 6 months.

MEDICATION LIST

List any medications you have taken in the last 90 days

☐Not currently taking any medications

Name/Type of Medication	Dosage/ Frequency	Date of Last dose

Intentionally blank

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INFECTIOUS DISEASE RISK ASSESSMENT FORM

This form is available in alternative formats including large print, other Languages and oral presentation. Let us know if you need any assistance completing this form

Select or complete the answer for each question.

1. Have you seen a doctor or other health care provider in the past 3 months?	☐ Yes	☐ No	☐ Don't Know
2. Do you live or have you lived on the street or in a shelter?	☐ Yes	☐ No	☐ Don't Know
3. Have you ever been in jail/prison/juvenile detention?	☐ Yes	☐ No	☐ Don't Know
4. Have you ever been in a long-term care facility (nursing home, mental health hospital, or other hospital)?	☐ Yes	☐ No	☐ Don't Know
5. Where were you born? _____			
6. In the past 3 years have you traveled/lived outside the U.S. (except Canada, Australia, New Zealand, Japan, Western Europe, or Great Britain)?	☐ Yes	☐ No	☐ Don't Know
7. How long have you been in the U.S.?			
8. Are you a combat veteran?	☐ Yes	☐ No	☐ Don't Know
9. In the past 12 months have you had a tattoo, ear/body piercing, acupuncture or come into contact with someone else's blood?	☐ Yes	☐ No	☐ Don't Know

10. Within the last 30 days, have you had any of the following symptoms lasting for more than 2 weeks:

- ☐ Nausea
- ☐ Fever
- ☐ Productive cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Lumps or swollen glands in the neck or armpits
- ☐ Diarrhea (runs) lasting more than a week
- ☐ Losing weight without meaning to
- ☐ Brown-tinged urine
- ☐ Women: Have you missed your last two periods?
- ☐ Extreme fatigue
- ☐ Jaundice (yellow skin) or yellow eyes
- ☐ Drenching night sweats that were so bad you had to change your clothes or the sheets on the bed.

11. Have you ever been told you have TB? Has anybody you know or have lived with been diagnosed with TB in the past year?	☐ Yes	☐ No	☐ Don't Know
12. Have you ever had a positive skin test for TB? (A test where they gave you a shot in your forearm, and a few days later a hard lump appeared.)	☐ Yes	☐ No	☐ Don't Know
13. Have you ever been treated for TB?	☐ Yes	☐ No	☐ Don't Know

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14. Have you ever been told you have:			
Hepatitis A	☐ Yes	☐ No	☐ Don't Know
Hepatitis B	☐ Yes	☐ No	☐ Don't Know
Hepatitis C	☐ Yes	☐ No	☐ Don't Know
15. Have you **ever** used needles to shoot drugs?	☐ Yes	☐ No	☐ Don't Know
16. Have you **ever** shared needles or syringes ("rigs") to inject drugs?	☐ Yes	☐ No	☐ Don't Know
17. Have you ever had a job that put you in danger of needle stick injuries or other types of blood contact?	☐ Yes	☐ No	☐ Don't Know
18. Do you use stimulants (cocaine/methamphetamine)?	☐ Yes	☐ No	☐ Don't Know
19. In the past 12 months, have you, or anyone you have had sex with, had: syphilis, gonorrhea, herpes, Chlamydia, nongonococcal urethritis, other sexually transmitted diseases, or hepatitis?	☐ Yes	☐ No	☐ Don't Know

To help find out if you are at increased risk for HIV, the virus known to cause AIDS, or Hepatitis C Virus (HCV), please take a minute to answer the following questions.

20. Did you receive a blood transfusion before 1992?	☐ Yes	☐ No	☐ Don't Know
21. Have you received blood products produced before 1987 for clotting problems?	☐ Yes	☐ No	☐ Don't Know
22. Was your birth mother infected with Hepatitis C virus during the time of your birth?	☐ Yes	☐ No	☐ Don't Know
23. Have you been, or are you currently, on long-term kidney dialysis?	☐ Yes	☐ No	☐ Don't Know
24. Have you had unprotected sex with someone who has the blood disease hemophilia?	☐ Yes	☐ No	☐ Don't Know
25. Have you had unprotected sex with a man who has sex with other men?	☐ Yes	☐ No	☐ Don't Know
26. Have you had sex in exchange for money or drugs, or in order to survive?	☐ Yes	☐ No	☐ Don't Know
27. Have you had sex with more than one person in the past 6 months? Any type of vaginal, rectal or oral contact without protection (condom or other barrier) with or without your consent?	☐ Yes	☐ No	☐ Don't Know
28. Have you had sex or shared needles to inject drugs with a person who has AIDS or who tested positive on the antibody test for AIDS/HIV disease or Hepatitis C?	☐ Yes	☐ No	☐ Don't Know
29. Have you ever injected drugs, even once?	☐ Yes	☐ No	☐ Don't Know
30. Have you ever been pricked by a needle or syringe that may have been infected with HIV or Hepatitis C virus?	☐ Yes	☐ No	☐ Don't Know
31. Have you ever had a drinking problem that required medical care or counseling?	☐ Yes	☐ No	☐ Don't Know
32. Have you ever been told or thought that you have a drinking problem?	☐ Yes	☐ No	☐ Don't Know

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33. Have you ever been told or thought that you have a drinking problem? ☐ Yes ☐ No ☐ Don't Know

*If you answered "no" to all the questions, you are not at increased risk for HIV/AIDS or Hepatitis C.

*If you answered "yes" or "don't know" to any question, you may be at risk for HIV/AIDS or Hepatitis C.

The following questions are asked to help with treatment planning. It is not required that you answer them to participate in assessment and/or treatment.

1. Have you ever had a blood test for the HIV antibody? ☐ Yes ☐ No

   If "no," would you like a blood test? ☐ Yes ☐ No

   If "yes," have you been tested within the last six months? ☐ Yes ☐ No

2. Have you ever had a blood test for Hepatitis C virus? ☐ Yes ☐ No

   If "no," would you like a blood test? ☐ Yes ☐ No

   If "yes," have you been tested within the last six months? ☐ Yes ☐ No

3. How would you judge your own risk for being infected with HIV (the AIDS virus)?

   ☐ I know I am infected. ☐ I think I am at low risk. ☐ I am not sure what my risk is.

   ☐ I think I am at high risk. ☐ I think I am at NO risk.

4. How would you judge your own risk for being infected with Hepatitis C?

   ☐ I know I am infected. ☐ I think I am at low risk. ☐ I am not sure what my risk is.

   ☐ I think I am at high risk. ☐ I think I am at NO risk.

(Notes for Intake Specialist: Document whether client was assessed and if they were referred to the health department or other appropriate agency.)

PLEASE NOTE- THIS FORM WILL BE DESTROYED AFTER IT HAS BEEN REVIEWED BY INTAKE SPECIALIST.