



# COMPREHENSIVE ASSESSMENT

**Client Name:** \_\_\_\_\_ **ID#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Would you like to be referred to by any other name?** \_\_\_\_\_ **Assessment Start Date:** \_\_\_\_\_

## MEDICAL

All medical information must be verified and documented. This includes verification of HIV status, most recent lab results, and TB status. Examples of verification include, but are not limited to, lab reports, HASA enrollment, letter from a physician or medical provider, or medical personnel, i.e. social worker, etc.

### HIV/AIDS STATUS (Primary Diagnosis):

What is current HIV status? (From medical verification, where possible):

\_\_\_ HIV+/Asymptomatic                      \_\_\_ HIV+/Symptomatic                      \_\_\_ AIDS

Transmission Route \_\_\_\_\_

\_\_\_ Pending Test/Unknown-at Risk      If unknown, what are the risk factors? \_\_\_\_\_

Verification in chart?    \_\_\_ Yes    \_\_\_ No      Method of verification: \_\_\_\_\_

Does client want to be tested for antibodies to HIV?    \_\_\_ Yes (discuss pre-test counseling/referral)    \_\_\_ No

## CURRENT MEDICAL CARE

**Is client receiving medical care?**    \_\_\_ Yes    \_\_\_ No

**Is client enrolled in a SNP?**    \_\_\_ Yes    \_\_\_ No    **If no, other Managed Care Plan?**    Yes    No

If yes, SNP or Plan name: \_\_\_\_\_                      CM: \_\_\_\_\_

### LIST PHYSICIANS, HOSPITALS, AND HEALTH CLINICS WHERE CLIENT RECEIVES HIV HEALTH CARE TREATMENT AND/OR OTHER HEALTH CARE SERVICES:

Type of Provider	Name	Full Address/Phone	Contact	Date of last visit
<b>4</b> HIV Primary Care:	<b>5</b>	<b>5</b>		<b>6</b>
Gyn (if different):				
Other (ex: Urologist):				

### How often does client see PCP?

**7** Date of Most Recent Viral Load \_\_\_\_\_      **8** Viral Load Results \_\_\_\_\_      **9** Date of Most Recent CD4 Count \_\_\_\_\_      **10** CD4 Count Results \_\_\_\_\_

Has medical information been verified?

\_\_\_\_\_

Does client understand meaning of VL & T-Count and how to read lab results? (Explain):

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Does client need referral for further HIV information/education? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does client schedule own appointments? \_\_\_\_\_ Yes \_\_\_\_\_ No

Identify any barriers that prevent client from keeping appointments:

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How does client assess/perceive level of HIV care received from PCP?

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Last hospitalization: \_\_\_\_\_ Place: \_\_\_\_\_

Nature of most recent hospitalization: \_\_\_\_\_

In client's own words, how would she/he describe her/his health? (Has her/his health recently improved or declined; has there been a significant change in T-cell/VL; are there concerns around her/his health; does she/he think the medication regimen is working, etc.)

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**HIV Related Medical Problems:** Indicate opportunistic infections reported by client or physician. The following lists common AIDS related illnesses. Check if yes and indicate the last date of illness/infection. This is **not** a comprehensive list. Please list any other HIV related medical problems under "Other HIV Related Symptoms" and include the last date of illness/infection.

	Yes	Date		Yes	Date
Candidiasis of bronchi, trachea, or lungs	_____	_____	Kaposi's Sarcoma	_____	_____
Candidiasis, esophageal	_____	_____	Lymphoma, Burkett's	_____	_____
Cervical cancer, invasive	_____	_____	Lymphoma, immunoblastic	_____	_____
Oral Thrush	_____	_____	Lymphoma, brain	_____	_____
Cryptococcus, extra pulmonary	_____	_____	Mycobacterium Avium Complex	_____	_____
Cryptosporidiosis, intestinal	_____	_____	Mycobacterium Tuberculosis	_____	_____
Cytomegalovirus Disease	_____	_____	Pneumocystis pneumonia (PCP)	_____	_____
Cytomegalovirus Retinitis	_____	_____	Pneumonia, recurrent	_____	_____
Encephalopathy, HIV-related	_____	_____	Multifocal leukoencephalopathy	_____	_____
Herpes Simplex, recurrent	_____	_____	Recurrent Vaginal Candidiasis	_____	_____
Histoplasmosis	_____	_____	Toxoplasmosis, brain	_____	_____
Peripheral Neuropathy	_____	_____	Wasting Syndrome	_____	_____
Avascular (i.e. bone) necrosis	_____	_____	Lipodystrophy	_____	_____

**OTHER HIV RELATED SYMPTOMS:**

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## MEDICATIONS

**The AIDS Institute updates the Medication List form on a quarterly basis for use with assessments and reassessments. Using the most recent copy of the AI Medication List form - please print a blank form, complete and replace this page with client's current medications.**

**ALLERGIES/ASTHMA - List known allergies:**

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\_\_\_\_\_ No known allergies

Does client suffer from Asthma? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If Yes, is client being treated via Meds/Inhaler/Oxygen? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Does the client smoke? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Does the client indicate willingness to stop smoking? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Does client want/need referral to Stop Smoking Program? \_\_\_\_\_ Yes \_\_\_\_\_ No

Other conditions (ex. Diabetes, Hypertension, Heart Disease, etc.):

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**ADHERENCE**

**13** Based on the current **Medications Page**, is client currently prescribed ARV therapy? \_\_\_\_\_ Yes \_\_\_\_\_ No

How does she/he feel about taking the prescribed medication? \_\_\_\_\_

What is important to her/him about her/his medication? \_\_\_\_\_

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**CLIENT ADHERENCE QUESTIONNAIRE** Please ask each question and each possible response, and circle the corresponding number next to the client's answer. Then add up the circled numbers to calculate the score.

1) How often do you feel that you have difficulty taking your HIV medications **on time**? By "on time" I mean no more than two hours before or two hours after the time your doctor told you to take it.

- 4 Never
- 3 Rarely
- 2 Most of the time
- 1 All of the time

2) **On average**, how many days **PER WEEK** would you say that you **missed at least one dose** of your HIV medications?

- 1 Everyday
- 2 4-6 days a week
- 3 2-3 days a week
- 4 Once a week
- 5 Less than once a week
- 6 Never

3) When was the **last time you missed at least one dose** of your HIV medications?

- 1 Within the past week
- 2 1 – 2 weeks ago
- 3 3 – 4 weeks ago
- 4 Between 1 and 3 months ago
- 5 More than 3 months ago
- 6 Never

**14** SCORE: \_\_\_\_\_ Greater than 10 = good adherence \_\_\_\_\_ Less than or equal to 10 =poor adherence \_\_\_\_\_

Does the client understand the consequences of missing doses? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Does she or he know enough about the medication she/he is taking? \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain the client's level of understanding regarding the need to eat/not eat with certain medications:

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From what pharmacy does the client access medications? \_\_\_\_\_

**ADHERENCE CONCERNS/INSIGHTS:** Summarize your discussion about "taking medications" and the client's understanding of the consequences of missing a dose. Discuss side effects, difficulties following regimen, and barriers to taking medications *as prescribed*. **:NOTE: If the participant has serious barriers to understanding medications and/or adhering to their medication regime summarize below. Add to Service Plan, notify primary care provider, and set up an appointment with an adherence specialist/treatment educator/supervisor.**

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### CLINICAL TRIALS

Does the client know what a Clinical Trial is? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Has the client ever participated in Clinical Trials? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Is the client currently participating in a trial? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Is the client interested in discussing options? \_\_\_\_\_ Yes \_\_\_\_\_ No

*(Any information related to Clinical Trials should be discussed during the next medical case conference)*

**WOMEN'S HEALTH ISSUES**

Date of last OB/GYN exam: \_\_\_\_\_

11 Date of most recent Pap Smear \_\_\_\_\_ Results \_\_\_\_\_

Was Pap test done within the past year? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is client pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No

LMP (last menstrual cycle): \_\_\_\_\_

(Discuss if time sequence seems unusually long): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If over age 40, approximate last date of mammogram: \_\_\_\_\_ Results \_\_\_\_\_

**Sexually Transmitted Disease (STD) History:**

STD	Date of Diagnosis	Treatment		Comments (current symptoms, on meds)
		Yes	No	
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What are client's thoughts on family planning? \_\_\_\_\_

Is family planning in place? \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_

**If client is pregnant, complete the following:**

Estimated # of weeks \_\_\_\_\_

Is client receiving prenatal care? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is client on Anti-Retroviral Therapy? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has client informed HASA/PA worker of pregnancy (budget revisions)? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Other women's health issues/comments** (include client's need for regular mammograms if over 40, menopause if applicable, description of client's hygiene, etc.):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEN'S HEALTH ISSUES**

Has client undergone a Prostate Exam? \_\_\_\_\_ Yes \_\_\_\_\_ No Date: \_\_\_\_\_

Has client undergone a Testicular exam? \_\_\_\_\_ Yes \_\_\_\_\_ No Date: \_\_\_\_\_

**Sexually Transmitted Disease (STD) History:**

STD	Date of Diagnosis	Treatment		Comments (current symptoms, on meds)
		Yes	No	
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What are client's thoughts on family planning? \_\_\_\_\_

Is family planning in place? \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OTHER MEN'S HEALTH ISSUES/COMMENTS**

(Include description of client's hygiene; inquire if client is taking erectile dysfunction medication, i.e., Viagra, Cialis or Levitra):

\_\_\_\_\_

\_\_\_\_\_

**TRANSGENDER HEALTH ISSUES**

How does client identify? \_\_\_\_\_

HRT (hormone replacement therapy)? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, date started? \_\_\_\_\_

How does client access HRT? \_\_\_\_\_

Name of physician if prescribed by other than regular PCP: \_\_\_\_\_

Is regular PCP aware of other physician's treatment? \_\_\_\_\_ Yes \_\_\_\_\_ No

STD	Date of Diagnosis	Treatment		Comments (current symptoms, on meds)
		Yes	No	
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other transgender health issues/comments (include client's need for referrals to transgender specific health care or Gender Identity Project, etc., description of client's hygiene, etc.):

\_\_\_\_\_

\_\_\_\_\_

**GENERAL HEALTH ISSUES**

**TUBERCULOSIS**

Client's TB status is:  Positive  Negative  Anergic  Not Known

Client on TB medications?  Yes  No PPD Date: \_\_\_\_\_ Chest X-Ray Date: \_\_\_\_\_

Is client currently on Directly Observed Therapy (DOT)?  Yes  No

If yes, program is: \_\_\_\_\_ If no, need for DOT referral?  Yes  No

Is client experiencing any barriers to taking medications on schedule?  Yes  No

If yes, explain:

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Has client completed TB treatment in the past?  Yes  No Date completed \_\_\_\_\_

Follow-up needed for family/collaterals? Describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HEPATITIS**

Has client ever been treated for Hepatitis?  Yes  No Type: A  B  C

Is client currently being treated for Hepatitis?  Yes  No Type: A  B  C

Type of Treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the client been screened for Hepatitis?  Yes  No

Results of Hepatitis Antibody Tests: A  B  **12** C

If the client is Hepatitis C antibody positive, has the client had HCV viral load testing for chronic HCV infection?  Yes  No  Unknown  N/A

**12** a Does the client have chronic Hepatitis C infection?  Yes  No  Unknown  N/A

Has client been vaccinated? A  B  No

Has client been provided information on Hepatitis and HIV (Hepatitis/HIV pamphlet)?  Yes  No

<b>Additional info/Follow up needed:</b>

**All medical information discussed thus far should be verified, documented, and discussed with the medical provider either via the social worker, nurse practitioner, or if necessary, the physician.**

**DENTAL CARE**

Does client receive ongoing dental care?  Yes  No Date of last visit: \_\_\_\_\_

Provider: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

Comments on dental problems or barriers to services (i.e. lack of access to providers, fear of dentists, etc.):

**VISION CARE**

Does client receive ongoing vision care?  Yes  No Date of last visit: \_\_\_\_\_

Provider: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

Comments on vision problems or barriers to services (i.e. lack of access to providers, fear of exam, etc.):

**NOTE:** *If CD4<200, explain to client possible effects of HIV on vision (i.e. CMV retinitis) and add to service plan objective of completing eye exam EVERY SIX MONTHS.*

**WELLNESS**

**NUTRITION**

Ask client to describe appetite:

How many meals during the day? \_\_\_\_\_ Type of food (fast food, cooks at home)? \_\_\_\_\_

Is client taking food supplements?  Yes  No **If yes, please add to medication section.**

Has client experienced a significant weight change recently?  Yes  No Explain any change:

Does client need a referral to a nutritionist?  Yes  No

**COMPLEMENTARY/ALTERNATIVE THERAPIES**

Is the client accessing complementary/alternative therapy (i.e. massage, acupuncture, herbal remedies)?  Yes  No

Explain:

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Is client interested in obtaining information on complementary/alternative therapies?  Yes  No

Comments:

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(If client expresses interest, discuss interest or use during next medical case conference)

**HOME CARE**

Is client currently receiving home care?  Yes  No (When no, SKIP to bolded area in HOME CARE section.)

Home Care Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Nurse/Home Health Aide: \_\_\_\_\_

How does client feel about current home care? \_\_\_\_\_

Indicate which services are being utilized:

Nursing  Visits per week  Occupational therapy  Days per week  
 Physical Therapy  Days per week  Other \_\_\_\_\_

**Is client in need of an evaluation for home care services?**  Yes  No

Comments:

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**TRANSPORTATION**

Does client have regular access to transportation?  Yes  No  Inconsistent \_\_\_\_\_

What is client's usual method of transportation? \_\_\_\_\_

Describe client's transportation needs: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMPLOYMENT/EDUCATION**

**EMPLOYMENT STATUS:**

Employed \_\_\_ Job Training Program \_\_\_ Stipend position \_\_\_ Unemployed \_\_\_ Disabled \_\_\_

Comments (employer information, occupation, hours per week, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments (name of job training program and counselor, phone #): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments (previous job history): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE: When client states she/he works “off the books,” please advise the client of the need to alert the DSS/HASA/HRA worker of the additional income; also remind the client of the need to report any income to appropriate government agencies (i.e. IRS).**

**EDUCATION**

Indicate highest grade/degree of education reached by client: \_\_\_\_\_  
\_\_\_\_\_

What language(s) does client speak fluently? \_\_\_\_\_  
\_\_\_\_\_

Can client:  
Read English? \_\_\_ Yes \_\_\_ No Read (other)? \_\_\_ Yes \_\_\_ No Name of language(s): \_\_\_\_\_

Write in English? \_\_\_ Yes \_\_\_ No Write (other)? \_\_\_ Yes \_\_\_ No  
Comment on client’s interest in educational opportunities (GED) and/or job training:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FINANCIAL RESOURCES/ENTITLEMENTS**

Total monthly income: \_\_\_\_\_ Total Monthly Expenses: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Source	Amount	Source	Amount
Wages	_____	Alimony	_____
Social Security	_____	Child Support	_____
Public Assistance	_____	Unemployment	_____
SSI/SSD	_____	Veteran's Benefits	_____
Medicaid/Medicare	_____	Enhanced Rent	_____
HASA	_____	Energy Assistance	_____
ADAP	_____	Food Stamps	_____
WIC	_____	Other	_____

Does client have outstanding debts? \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain:

\_\_\_\_\_

Does client have a representative payee? \_\_\_\_\_ Yes \_\_\_\_\_ No Who? \_\_\_\_\_

Is client/household income sufficient to meet basic needs? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, explain situation:

\_\_\_\_\_

Evaluate client's ability to manage his/her own finances:

\_\_\_\_\_

Does the client need a fair hearing/appeal process for any denials of entitlements? \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain situation:

\_\_\_\_\_

**Medicaid re-certification date:** \_\_\_\_\_ **Any spend-down amount?** \_\_\_\_\_

Is client in need of a referral for additional food sources (i.e. Momentum Food Project, God's Love We Deliver, local soup kitchens, etc.)? \_\_\_\_\_ Yes \_\_\_\_\_ No (If yes, add to Service Plan)

Name of HASA/PA Worker: \_\_\_\_\_ Phone #: \_\_\_\_\_

Comments (include any difficulties with worker):

\_\_\_\_\_

**HOUSING**  
**A HOME VISIT MUST BE COMPLETED AS PART OF THE ASSESSMENT PROCESS**

Date of home visit: \_\_\_\_\_

If home visit not conducted, why? \_\_\_\_\_

Current housing situation (rent apartment, scatter-site, \_\_\_\_\_  
 congregate, nursing home, shelter, SRO, friends): \_\_\_\_\_

Has client been assisted with housing before? \_\_\_ Yes \_\_\_ No If yes, by whom? \_\_\_\_\_

How many times has client moved from apartments in the past 5 years? \_\_\_\_\_

Reasons: \_\_\_\_\_

Can client pay her/his portion of the rent?	___ Yes ___ No	Does client have a checking account?	___ Yes ___ No
Can client write out a check/money order?	___ Yes ___ No	Does client have problems paying the rent?	___ Yes ___ No
Has client been in rent arrears?	___ Yes ___ No	Is client legally assisted with rent issues?	___ Yes ___ No
Has client ever lived alone?	___ Yes ___ No	Does client feel comfortable living alone?	___ Yes ___ No
Does client plan to live alone?	___ Yes ___ No	If no, with whom?	

Does client think she/he would benefit from living in supportive living? \_\_\_ Yes \_\_\_ No

Does client have concerns living in housing provided by an AIDS organization? \_\_\_ Yes \_\_\_ No

Summary (current housing situation and condition, barriers to housing placement, financial management, and possible referrals): \_\_\_\_\_

22 Based on the case manager's housing assessment, status can be described as: \_\_\_\_\_

Homeless or Temporary Shelter	Inadequate and/or Unstable	Adequate and Stable
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**PARENTING, FAMILY, AND SOCIAL SUPPORTS**

Does client have any minor children under the age of 21? \_\_\_ Yes \_\_\_ No (If no, skip.)

Complete regardless of child's HIV status or living arrangement. For minor children living outside of the home, an assessment needs to be completed indicating what needs the child may have and who the primary caregiver is that is meeting these needs (address any deficits in meeting child's needs). List all minor children considered to be part of the household:

Name	Sex	Age	HIV Status	Living in home? (Yes or No)	Living with other? (specify)	Aware of client's HIV status? (Yes or No)	Aware of own HIV status? (Yes or No)
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Describe current relationship with children listed above: \_\_\_\_\_

If client has minor children living outside of the home, does client wish to have increased contact and/or custody of children?       Yes     No    Comments: \_\_\_\_\_

Is there a need for any of the following:  
Parenting skills training?       Yes     No    Specify: \_\_\_\_\_

Respite care?       Yes     No    Specify: \_\_\_\_\_

Child Care?       Yes     No    Specify: \_\_\_\_\_

Is there suspected/confirmed child abuse/neglect?       Yes     No    Explain: \_\_\_\_\_

Is CPS/ACS involved?       Yes     No    Explain: \_\_\_\_\_

**NOTE: It is our responsibility as mandated providers to report suspicion of child abuse and/or neglect.**

**FAMILY SUPPORT [Not minor children]**

Client's current spouse/partner: \_\_\_\_\_ Spouse/Partner's HIV status: \_\_\_\_\_

Is spouse/partner aware of client's HIV status?     Yes     No     Not sure

Is client in need of a referral to partner notification services?       Yes     No

Who does client identify as other family/collateral support or significant others? (Include parents, siblings, significant others who ARE supportive.)

Name	Relation-ship	Age	HIV Status	Address	Phone #	Aware of client's HIV status? (yes or no)
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Describe family relationship/patterns of communication, roles, and types of support:  
[i.e., Who would you go to if you were depressed, needed money, needed someone to talk to, etc.?)

Are the client's parents living?    Mother:     Yes     No                  Father:     Yes     No  
If yes, describe your relationship: \_\_\_\_\_

How would you describe your childhood?  
\_\_\_\_\_  
\_\_\_\_\_

## DOMESTIC VIOLENCE

### DOMESTIC VIOLENCE ASSESSMENT

Does the client report feeling unsafe in her/his current living arrangement?     Yes     No

If yes, describe:

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How is the situation today?

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Does the client report feeling afraid that she/he will resort to physical force when interacting with a significant other OR her/his children?     Yes     No    Explain any "Yes" answers:

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Does the client believe that domestic violence is an issue at this time?     Yes     No    If yes, explain:

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Is client currently in a program that is addressing this issue?     Yes     No    If yes, explain:

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If client does not believe that violence is an issue, does **worker** have any reason to believe that this is an issue?     Yes     No    If yes, explain:

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## PARTNER/SPOUSAL NOTIFICATION

Are there past/present partners (sexual or needle sharing) with whom the client has **not** discussed her/his HIV status with?     Yes     No  
(if no, skip this section)

***Discuss importance/benefits of partner notification with client!***

Options Discussed:     Self Notification     Notification with assistance by PNAP/CNAP  
                                   Joint Notification                                    Notification by Health and Human Service Provider  
                                   Client declines to notify partner

**What issues need to be resolved to encourage partner/spousal notification?**

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## SUBSTANCE ABUSE AND MENTAL HEALTH

### SUBSTANCE ABUSE HISTORY

**Drugs used currently or in the past:**

	<u>Type</u>	<u>Frequency of Use</u>	<u>Route of Administration</u>	<u>Amount</u>	<u>Date of Current and/or Last Use</u>
	Alcohol	_____	_____	_____	_____
	Marijuana	_____	_____	_____	_____
	Cocaine	_____	_____	_____	_____
	Crack	_____	_____	_____	_____
	Heroin	_____	_____	_____	_____
	Hallucinogens	_____	_____	_____	_____
	Crystal Meth	_____	_____	_____	_____
	Other	_____	_____	_____	_____

**15** Does client have a history of problem drug or alcohol use? Yes No  
\_\_\_\_\_ \_\_\_\_\_

### TREATMENT HISTORY

Has client ever sought treatment for alcohol/drug use? \_\_\_ Yes \_\_\_ No. If no, leave blank and skip to Mental Health History.

Past Dates	Modality	Place	Completed? <small>(yes or no)</small>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Note past barriers to or reasons why program was not completed:

\_\_\_\_\_

\_\_\_\_\_

### CURRENT SUBSTANCE USE SERVICES

**16** Is client currently enrolled in substance use services? Yes No  
\_\_\_ \_\_\_

<b>17</b> & <b>17</b> a. Current modalities	<b>17</b> Date Started	Comments
Harm reduction/Needle exchange	_____	_____
AA/NA or other self-help group	_____	_____
Recovery Readiness	_____	_____
Inpatient substance use program	_____	_____
Inpatient alcohol program	_____	_____
Outpatient alcohol program	_____	_____
Outpatient substance use program	_____	_____
Methadone Maintenance (# of mg)	_____	_____
Detox (7 day or 28 day)	_____	_____

Name and address of program attending: \_\_\_\_\_

\_\_\_\_\_

Worker name: \_\_\_\_\_

Worker phone #: \_\_\_\_\_

**If Client is Attending Outpatient Program**

Frequency of visits: \_\_\_\_\_

**17** a.1. Over the past 6 months has attendance been \_\_\_\_\_ Inconsistent or \_\_\_\_\_ Consistent?

Comment on client's ability to keep appointments:

\_\_\_\_\_

Regardless of treatment history, does the client consider her/himself in recovery? \_\_\_\_\_ Yes \_\_\_\_\_ No

What has helped client remain sober?

\_\_\_\_\_

Does client have an awareness of what her/his relapse "triggers" are? Discuss:

\_\_\_\_\_

**If client is ACTIVELY using a substance:**

Are harm reduction methods being used? \_\_\_\_\_ Yes \_\_\_\_\_ No (Refer to HIV Prevention) Explain:

\_\_\_\_\_

Does client indicate or state a willingness to stop? \_\_\_\_\_ Yes \_\_\_\_\_ No Explain: \_\_\_\_\_

\_\_\_\_\_

What attempts have been made to stop using?

\_\_\_\_\_

Evaluate client's willingness to stop using alcohol/drugs:

\_\_\_\_\_

**16** Based on your assessment, does the client need a referral for substance use services? \_\_\_\_\_ Yes \_\_\_\_\_ No

**MENTAL HEALTH HISTORY**

Has client ever received psychiatric or mental health treatment?     \_\_\_ Yes     \_\_\_ No

If yes, please indicate diagnosis as reported by client: \_\_\_\_\_

If yes, please indicate symptoms as reported by client: \_\_\_\_\_

Comments (If yes above, please conference with mental health providers):  
\_\_\_\_\_  
\_\_\_\_\_

**Current and Past Modalities**

<b>19 &amp; 19 a.</b> Check Modality	Date	Comments
_____ Individual counseling/therapy	_____	_____
_____ Family counseling	_____	_____
_____ Outpatient psych (Private PhD/MD)	_____	_____
_____ Inpatient psychiatric care	_____	_____
_____ Other mental health care	_____	_____
_____ Support group	_____	_____

Has client ever been hospitalized for a psychiatric condition?     \_\_\_ Yes     \_\_\_ No

Dates: \_\_\_\_\_     Where: \_\_\_\_\_     For: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Clinician (current/most recent): \_\_\_\_\_     Frequency of Visits: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_

**19 a.1.** Does client keep mental health care appointments consistently?     \_\_\_ Yes     \_\_\_ No     Inconsistent because? \_\_\_\_\_

**20** Currently or ever prescribed medication for a psychiatric/emotional condition?     \_\_\_ Yes     \_\_\_ No

Prescribed Medication	<b>20</b> Last Use (approx. if in past year)	Dosage/Frequency	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Feelings about prescribed medication: \_\_\_\_\_

**21** Does client report adherence to this medication regimen?     \_\_\_ Yes     \_\_\_ No     \_\_\_ Inconsistent

Barriers to taking medication as prescribed: \_\_\_\_\_

Has client ever attempted suicide? \_\_\_ Yes \_\_\_ No Discuss (i.e. approximate dates, method, and precipitating events):

Has client ever had thoughts of hurting her/himself? \_\_\_\_\_ Yes\* \_\_\_\_\_ No Explain:

Does client have current suicidal ideation? \_\_\_\_\_ Yes\* \_\_\_\_\_ No  
If yes, does client have a plan? \_\_\_\_\_ Yes\* \_\_\_\_\_ No

**\*If yes, what is the plan? Discuss with supervisor.**

Has client ever had feelings of depression? \_\_\_\_\_ Yes \_\_\_\_\_ No Explain:

Significant losses/traumatic events? \_\_\_\_\_ Yes \_\_\_\_\_ No Explain:

**Self Image** [Ask the following questions and quote client]:

What do you see as your strengths?

What would you like to change about yourself?

What helps you cope with feelings of loss, stress, and depression?

Is client interested in counseling/therapy? \_\_\_\_\_ Yes \_\_\_\_\_ No Explain:

**In YOUR opinion:**

**18** Is a mental health evaluation warranted based on the above questions? \_\_\_\_\_ Yes \_\_\_\_\_ No Explain:

Is there a need for or interest in mental health services such as psychotherapy, psychiatric services, medication evaluation or others? \_\_\_\_\_ Yes \_\_\_\_\_ No  
\_\_\_\_\_ Individual \_\_\_\_\_ Family/Collaterals \_\_\_\_\_ Other:

**Explain:**



**LEGAL**

Has client ever been incarcerated?      \_\_\_ Yes      \_\_\_ No

If yes:

Where? _____	When? _____	Nature of _____
_____	_____	Incarcer- _____
_____	_____	ation: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is client currently on probation or parole? \_\_\_ Yes      \_\_\_ No

If yes, until when? \_\_\_\_\_ Name of Parole/Probation Officer: \_\_\_\_\_  
Phone # of Parole/Probation Officer: \_\_\_\_\_

Is client currently serving any type of sentence (i.e. community service hours, etc.)? \_\_\_ Yes      \_\_\_ No  
Explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does client have any outstanding warrants/summons/cases pending? \_\_\_ Yes      \_\_\_ No  
Explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is client in need of assistance with any of the following?

	Yes	No	In-Place	Comments
Health Care Proxy	_____	_____	_____	_____
Living Will	_____	_____	_____	_____
Power of Attorney	_____	_____	_____	_____
Immigration	_____	_____	_____	_____
Permanency Planning	_____	_____	_____	_____
Standby Guardianship	_____	_____	_____	_____

## HIV PREVENTION WITH POSITIVES

### SAFER SEX/DRUG USE:

Describe current risk behaviors:

---

The following risk and harm reduction information was discussed on (date): \_\_\_\_\_

Does the client currently have a sex partner or partners? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are their partner(s) aware of their own HIV status? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do they need help getting tested? \_\_\_\_\_ Yes \_\_\_\_\_ No

How is the client doing practicing safer sex?

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What works for the client and what doesn't when it comes to safer sex (e.g. condom use, dental dam, etc.)?

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Does being high or drinking get in the way of practicing safer sex? \_\_\_\_\_ Yes \_\_\_\_\_ No

Summarize discussion, including safer sex information provided:

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Would the client like to work with a trained counselor/educator person to help improve safer sex practices? \_\_\_\_\_ Yes \_\_\_\_\_ No

### IF THE CLIENT IS ALSO INJECTING DRUGS:

What works for the client and what doesn't when it comes to using a new or clean syringe and works with every shot?

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Does the client ever find her/himself in a situation where they are sharing syringes or works? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does the client know she/he can get clean syringes, help practicing safer drug use through a syringe exchange program, or purchase syringes at an ESAP pharmacy/hospital? \_\_\_\_\_ Yes \_\_\_\_\_ No

Summarize your discussion with the client about drug-related harm reduction methods:

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Do they need a referral? \_\_\_\_\_ Yes \_\_\_\_\_ No

## SUBSTANCE USE BEHAVIOR

Drug Use: \_\_\_\_\_ Yes \_\_\_\_\_ No

Needle Sharing: \_\_\_\_\_ Yes \_\_\_\_\_ No

Use of Bleach: \_\_\_\_\_ Yes \_\_\_\_\_ No

Comments: \_\_\_\_\_

**UNIVERSAL PRECAUTIONS**

Does the client understand how to protect household members from exposure to HIV?     \_\_\_ Yes   \_\_\_ No  
Briefly describe their understanding:

---

Does the client require referral for further information?     \_\_\_ Yes   \_\_\_ No

Comments:

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**OTHER AGENCIES SERVING THE CLIENT AND FAMILY/COLLATERALS:**

Name	Service	Agency Contact	Phone Number
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
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Please Note: This ASSESSMENT is not complete without the cover sheet.

All signatures are to be entered on the coversheet.