Colorado Health Network Medical Clinic

Intake for HIV Care

Patient Navigator:_____
Admission Date: _____
Intake Date: _____
Client #: _____
Referral Source: _____
Regional Office: _____

CONTACT INFORMATION:

Client Legal Name:

_____ _____ _____
First MI Last

Client Name:

_____ _____ _____
First MI Last

Pronoun(s):_____
(Ex. he/him, she/her, they/them)

Birth Date: _____ **Soc. Sec. Number:**_____

Proof of Legal Name:

(Please Circle One)

Driver's Lic | # _____ **(RWB)**

CO ID | ID # _____ **(RWB)**

Medicare Card **(RWB)** Social Security Card

Soc. Sec. Paperwork Medical Document

Birth Certificate Passport

Address:

_____
Street Apt#

_____ _____ _____
City State Zip

_____ ☐ Homeless ☐ Mail at CHN Office
County

May we mail CHN information to you at this address? Yes | No

Proof of residence:

(Please circle one)

Driver's Lic.| # _____**(RWB)**

CO ID | ID # _____**(RWB)**

Medicare Card **(RWB)** Medical Document

Lease Bill

Social Security Paperwork

Phone and Email:

Type:

Phone # _____ _____

Phone # _____ _____

Email _____ _____

Discreet?	**NO CALL**	**Message**
Yes | No	_____	**Yes | No**
Yes | No	_____	**Yes | No**
Yes | No	_____	**Yes | No**

EMERGENCY CONTACT INFORMATION:

Name	Relationship	Phone	Discreet?

Client Demographics:

Gender

Male

Female

Trans*(MTF)

Trans*(FTM)

Gender Queer

Gender Non-Conf.

Sex Assigned at Birth

Male
Female
Intersex

Ethnicity

Non-Hispanic
Hispanic (Specify):
Mexican Puerto Rican
Cuban Other Hispanic

Race (Circle all that apply)

White
Black
American Indian/Alaska Native
Asian (Specify):
Asian Indian Chinese Filipino
Japanese Korean Vietnamese Fill in

Native Hawaiian/Pacific Islander (Specify):
Native Hawaiian Guamanian Samoan
Fill in

Sexual Orientación

Heterosexual

Gay

Lesbian

Bisexual

Pansexual

Asexual

Undisclosed

Religious Affiliation:

Language(s):

_____
(Speak | Read | Write)

_____
(Speak | Read| write)

Client Country of Origin:

Living Situation:

Household, Dependents, and Roommate:

Name	Relationship	Gender	Ethnicity	Date of Birth	Custody?

Relationship Status:

(Please Circle One)

Single
Married
Committed Relationship
Polyamorous/ Open Relationship
Separated
Divorced
Client is a Child

Other:_____

Living Situation:

(Circle one) **Subsidized?**

Apartment Section 8
House/Condo HOPWA Unit
Shelter TBRA
Friend's Home Other
With Family
Homeless
Group Facility
Couch Surfing

Childcare Assistance?

(Please Describe Needs)

Education/Employment:

Education:

Highest Grade Completed:

Pre-HS High School
Collage Graduate
Post-Graduate

Diploma/GED Y | N

Employment:

Employer:_____

Full Time | Part Time **Hours per Week:**_____

Volunteer:_____

Hours per Week:_____

Unemployed: **Y | N** **Time unemployed:**_____

Income:

Please List ALL Sources of Income:

$_____Employment $_____Unemployment $_____SSI

$_____Food Stamps $_____Unreported $_____SSDI

$_____Inheritance/Trust $_____Interest Income $_____VA

$_____Alimony $_____Rental Income $_____TANF

$_____Child Support **$_____Total**

Percent:_____ **Cap:**_____

No Income: Yes | No

How Long: _____

Other Household Income:

Partner/Spouse $_____

Parent $_____

Dependent $_____

Transportation:

Does Client Qualify for Transportation Assistance? Yes | No

Reason for Ineligibility:_____

Health:

Medical Care / Care Team:

_____ Clinic	_____ Contact/Title	_____ Phone	_____ Type
_____ Clinic	_____ Contact/Title	_____ Phone	_____ Type
_____ Clinic	_____ Contact/Title	_____ Phone	_____ Type

Insurance

(Select ALL that Apply)

____Medicaid ____ADAP ____PHIP

____Medicare A ____CICP ____Gilead AA

____Medicare B ____VA ____Gilead Co-pay

____QMB ____Other ____None

___Private, Insurance (Carrier:_____)

Primary on Insurance:_____

Medicaid/Medicare/Private insurance #:_____

Dental Insurance:_____

HIV Status:

(Chose One)

___HIV Symptomatic
___HIV Asymptomatic
___AIDS Symptomatic
___AIDS Asymptomatic

_____
Date of Initial Diagnosis

Symptoms/Opportunistic Infection:_____

_____

_____

HIV/AIDS Risk Factor

(Please check all that apply)

_____Men who have had sex with men
_____IV drug use
_____Heterosexual contact
_____Hemophilia/Coagulation Disorder
_____Transactional Sex
_____Transfusion of blood (1975-1985) blood components, or tissue
_____Perinatal Transmission
_____Other (Please explain):_____

Current Labs:

(Please List Most Recent)

CD4 Count:_____ **Date:**_____

Viral Load:_____ **Date:**_____

HIV Health Continued:

Client Treatment Status:

Naïve
Experienced
Never on Meds

(Note: Naïve Currently on HAART regimen, but no prior ART or less than one (1) month prior ART experience.
Experienced: Currently on HAART regimen, and hand been on previous regimen for greater than (1) month.)

Side Effect:

_____

_____

_____

Adherence Difficulties:

_____

_____

_____

Doses Missed Past Seven (7) Days:_____

Reason Not On Meds:

_____

_____

_____

Current Medication:

(Please List ALL Current Medication, Type, and Start Date)

Medication	Use	Start Date
Medication	Use	Start Date
Medication	Use	Start Date
Medication	Use	Start Date
Medication	Use	Start Date
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Medication	Use	Start Date
Medication	Use	Start Date
Medication	Use	Start Date

How do you think you were acquired with HIV?

(Please select all that apply)

_____Opposite Sex Contact _____Same Sex Contact _____Transfusion

_____Sharing Needles _____Unsure _____Refused

_____Pre-Natal _____Other (Please Describe:_____)

Do you have a strong support system (family/friends/partner)? **Yes | No**

Do they know your HIV Status? **Yes | No**

Are you comfortable disclosing your status to sex or drug partners? **Yes | No**

Do you have any history of sexually transmitted infections (STI's)? **Yes | No**

Have you ever tested positive for?

_____ Hepatitis B
_____ Hepatitis C
_____ Gonorrhea
_____ Chlamydia
_____ Genital Herpes
_____ Anal Warts
_____ Genital Warts
_____ Scabies
_____ Crabs
_____ Pelvic Inflammatory Disease
_____ Cervicitis
_____ Non-Gonoccal (NGU)
_____ Proctatitis/ Proctocolitis
_____ Epidiymtis
_____ Trichomonasis
_____ Chancroid
_____ Lymphogranuloma Vernerum

Health Continued:

Other Medical: **Date/Location**

Have you seen a dentist in the last six (6) months? **Yes | No**_____

Would you like a dental referral? **Yes | No**_____

Have you had an eye exam in the last year? **Yes | No**_____

Would you like a vision referral? **Yes | No**_____

Do you have any physical or mental impairment that limits normal activities, including seeing, hearing, walking, or speaking?

_____

_____

Mental Health:

Mental Health Care/Care Team:

Clinic	Contact/Title	Phone	Type
Clinic	Contact/Title	Phone	Type
Clinic	Contact/Title	Phone	Type

Diagnosis:_____

_____

_____

Would you be interested in a counselling referral?

Yes | No

_____

(For what presenting issues? Please list.)

Trauma History:

Has anyone you know ever hit, kicked, or slapped you? Current Past Childhood Other

(Please describe to the degree that you are comfortable)

_____

_____

_____

_____

Substance Use:

Have you smoked Cigarettes or used other Tabaco products in the past 3 years? (Includes Vaping) **Yes | No**

On average, how many days a week do you drink alcohol? _____

What is the maximum number of drinks that you've had on any given day in the past month? _____

Do you use prescription drugs outside of physician guidelines? **Yes | No**

Have you quit using any substances in the last year? **Yes | No**

Please List:_____

In the past thirty days, have you used any of the following substances? (Outside of prescribed use)

☐ Marijuana
☐ Cocaine or Crack
☐Methamphetamine
☐Inhalants/ Nitrites (poppers)
☐Heroin
☐LSD
☐MDMA (ecstasy/ Molly)
☐DMT
☐Ketamine (special K)
☐ Viagra, Levitra, Cialis or other sex enhance drug
☐ Hormones
☐Amphetamine (Adderall)
☐ Methylphendiate (Ritalin)
☐Alprazolam (Xanax)
☐Clonazepam (Klonopin)
☐ Tramadol
☐Diazepam (Valium)
☐Zolpidem (Ambien)
☐Lorazepam (Ativan)
☐ Hydrocodone (Vicodin)
☐Morphine
☐Oxymorphone
☐Burprenorphine (Suboxone)
☐ Methadone
☐ Carisoprodol (SOMA)
☐ Other: _____

Are you currently, or have you ever been, in treatment for substance abuse? **Yes | No** **When?**_____

SBIRT Code:_____

Criminal History:

Have you ever been involved with the criminal justice system? **Yes | No**

Have you ever been convicted of a felony? **Yes | No**

Have you been incarcerated in the last three (3) months? **Yes | No**

Questions and or Concerns:

Do you have any questions or concerns you would like your medical provider to be aware of prior to your first appointment?

_____

_____

_____

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