Colorado Health Network Medical Clinic

Intake for PrEP

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 Orientation

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
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 $_____

Food Bank:

Does Client Qualify For Food Bank (If Available)? **Yes | No**

Is Client TFAP/USDA Eligibility (Income < 185% FPL)? Y | N

Reason for Ineligibility:_____

Transportation:

Does Client Qualify for Transportation Assistance? Yes | No

Reason for Ineligibility:_____

Health:

Medical Care / Care Team:

Clinic	Contact/Title	Phone	Type

Insurance

(Select ALL that Apply)

____Medicaid ____ADAP

____Medicare A _____ PHIP

____Medicare B ____VA

____QMB ____Other ____None

___Private, Insurance (Carrier:_____)

____ Gilead Advancing Access _____ Gilead Co-Pay Card

Primary on Insurance:_____

Medicaid/Medicare/Private insurance #:_____

STI and HIV Status:

Most recent HIV Test:_____

HIV/AIDS Risk Factor

(Please check all that apply)

_____Men who have had sex with men _____Hemophilia/Coagulation Disorder

_____ Transactional Sex _____ Perinatal Transmission

_____ IV drug use _____Heterosexual contact

_____ Transfusion of blood (1975-1985) _____Other (Please explain)

(blood components, or tissue)

Have you ever tested positive for?

_____ Hepatitis B _____ Pelvic Inflammatory Disease

_____ Hepatitis C _____ Trichomonasis

_____ Gonorrhea _____ Scabies

_____ Chlamydia _____ Crabs

_____ Genital Herpes _____ Epidiymtis

_____ Genital Warts _____ Cervicitis

_____ Anal Warts _____ Proctatitis/ Proctocolitis

_____ Chancroid _____ Lymphogranuloma Vernerum

_____ Non-Gonoccal (NGU)

Health Continued:

Client Treatment Status:

Naïve
Experienced
Never been on PrEP

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	Type	Start Date
Medication	Type	Start Date
Medication	Type	Start Date
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Medication	Type	Start Date

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**_____

Other Medical Screenings:

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
☐ Steroids
☐ 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?

_____

_____

_____