

Michigan HIV Medical Case Management PILOT Biopsychosocial Reassessment

Client Information

Full Legal Name			Date of birth		
Preferred Name			Gender Pronoun		
Street Address					City
State	Zip	County	Send mail to this address? <input type="checkbox"/> Yes <input type="checkbox"/> No		Confidential mail required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address (if different from above)					City
State	Zip	County	Send mail to this address? <input type="checkbox"/> Yes <input type="checkbox"/> No		Confidential mail required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Phone			Leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Send text? <input type="checkbox"/> Yes <input type="checkbox"/> No	Confidential message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cell Phone			Leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Send text? <input type="checkbox"/> Yes <input type="checkbox"/> No	Confidential message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Alt Phone			Leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Send text? <input type="checkbox"/> Yes <input type="checkbox"/> No	Confidential message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email address			Send email to this address? <input type="checkbox"/> Yes <input type="checkbox"/> No		Confidential message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					

Emergency Contact Information

Name		Relationship			
Phone		Leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Send text? <input type="checkbox"/> Yes <input type="checkbox"/> No	Confidential message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this person aware of your HIV status? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this person on your ROI? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Information			
Name		Relationship			
Phone		Leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Send text? <input type="checkbox"/> Yes <input type="checkbox"/> No	Confidential message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this person aware of your HIV status? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this person on your ROI? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Information			

Transportation

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need	
If there are changes and/or this is a new/continuing need, then updates must be provided below.			
Do you have access to transportation for healthcare appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you need financial assistance with transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Client Name:

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Client DOB:

Transportation

What type of transportation do you use?

- Personal vehicle
 Volunteer/friends
 Public transportation
 Taxi service
 Van service
 Other:

Do you have disabilities that impact your access to transportation?
 Yes
 No

If yes, what disability?

Comments:

Housing

Since last (re)assessment, there has been:

- No changes
 Changes

This is a:
 New Need
 Continuing Need

Not a need

If there are changes and/or this is a new/continuing need, then updates must be provided below.

Type of housing:

- Rental
 Own home
 Nursing home
 Hospital
 Transitional living facility
 Shelter
 Living with others
 Living on streets
 Living in my car
 Prison/jail
 Other:

Is your housing stable?

- Yes
 No

If homeless, do you need help

finding shelter?
 Yes
 No

Number of people in household:

Who do you live with?

Name	Relationship	DOB (minors)	Aware of your HIV status?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Is housing subsidized?

- Yes
 No

By whom?

How much?

Have you applied for subsidized housing?

- Yes
 No

Where?

Do you have past due rent/mortgage/utilities?

- Yes
 No

Are you under threat of eviction/shut-off?

- Yes
 No

If yes to either question, explain:

Are you satisfied with current housing?

- Yes
 No

If no, explain:

Do you have adequate furniture and appliances in your home?

- Yes
 No

If no, explain:

How do you describe your neighborhood? (Assess safety, walkability, distance to bus stop, etc.)

Comments:

Client Name:

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Client DOB:

Children/Dependents

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need	
If there are changes and/or this is a new/continuing need, then updates must be provided below.			
Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of children	Ages	# living with you
If children don't live with you, where do they live?	Do any of the children have special needs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what?	
Have your parental rights been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you need assistance with caring for children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you need assistance with locating parenting classes? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you need assistance disclosing status to children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have your children been tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how many of your children are HIV-positive?	
Clinic where they receive HIV medical care		Name of HIV medical provider	
Do you need assistance with your children's HIV medical care/medications? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What is your relationship with children?			
Do you have other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of dependents	Ages	# living with you
If dependents do not live with you, where do they live?	Do you need assistance in caring for adult dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What is your relationship with dependents?			
Comments:			

Finances and Benefits

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need	
If there are changes and/or this is a new/continuing need, then updates must be provided below.			
INCOME AND EXPENSES			
Do you have income? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete chart below:			
MONTHLY INCOME	AMOUNT	MONTHLY EXPENSES	AMOUNT
Employment/wages (gross amount)		Rent/mortgage	
Unemployment		Utilities	
Alimony/child support		Phone	
Pension or retirement income		Food	
Social Security Retirement		Insurance premiums	
Worker's compensation		Medical expenses	
Social Security Disability Income		Medication expenses	
Supplemental Security Income		Car payment	
FIP/TANF		Transportation	
State Disability Assistance		Cable	

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Client DOB:

Finances and Benefits

MONTHLY INCOME	AMOUNT	MONTHLY EXPENSES	AMOUNT
Veteran's Benefits		Other:	
Other:		Other:	
Other:		Other:	
Other:		Other:	
TOTAL:		TOTAL:	
MONTHLY INCOME – EXPENSES			
Comments:			

EMPLOYMENT/DISABILITY

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need	
If there are changes and/or this is a new/continuing need, then updates must be provided below.			
Employment Status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Job training <input type="checkbox"/> Other:	Reason for being un/under employed: <input type="checkbox"/> Disabled-not HIV-related <input type="checkbox"/> Disabled-HIV-related <input type="checkbox"/> <input type="checkbox"/> Disinterested <input type="checkbox"/> Limited job skills <input type="checkbox"/> Waiting for disability <input type="checkbox"/> Other:		
If un/under-employed, would you like assistance getting a job or going back to school? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:		
If disabled, have you applied for disability assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If on disability, do you have a representative payee? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you able to meet basic monthly needs? <input type="checkbox"/> Yes <input type="checkbox"/> No	What financial support do you receive from family/friends?		
Do you have outstanding debt? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:		
Highest schooling completed: <input type="checkbox"/> 6 th grade or less <input type="checkbox"/> Between 7 th and 12 th grade <input type="checkbox"/> High school diploma <input type="checkbox"/> GED <input type="checkbox"/> Vocational training <input type="checkbox"/> College degree <input type="checkbox"/> Post-graduate work <input type="checkbox"/> Post-graduate degree <input type="checkbox"/> Other:			
Comments:			

INSURANCE

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need	
If there are changes and/or this is a new/continuing need, then updates must be provided below.			
Do you have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete chart below:			
If no insurance, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which insurance?		

Are you a veteran?	Are you eligible for VA benefits?	Have you applied for VA benefits?
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Client DOB:

INSURANCE						
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you eligible for Indian Health Services (IHS)? <input type="checkbox"/> Yes <input type="checkbox"/> No				Have you applied for IHS benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
INSURANCE/BENEFIT TYPE		INSURANCE/BENEFIT INFORMATION (list HMO, plan#, contact information, benefits limits, other costs)				
<input type="checkbox"/> Medicare <input type="checkbox"/> Part A (Hospitalization) <input type="checkbox"/> Part B (Medical) <input type="checkbox"/> Part C (Advantage) <input type="checkbox"/> Part D (Prescription)		Premium:	Part B	Part C	Part D	
<input type="checkbox"/> Medicaid <input type="checkbox"/> "Straight"/Full <input type="checkbox"/> HMO <input type="checkbox"/> Healthy Michigan <input type="checkbox"/> Spenddown		If applicable, recertification date If applicable, monthly contribution If applicable, spenddown amount				
<input type="checkbox"/> Private Health Plan <input type="checkbox"/> Employer-sponsored <input type="checkbox"/> COBRA <input type="checkbox"/> Individual Plan <input type="checkbox"/> Covered under someone else's policy		Premium		Med. visit co-pay		
		Deductible		Med. co-pay		
		Co-insurance		Other		
<input type="checkbox"/> ACA Qualified Health Plan		Premium		Med. visit co-pay		
		Deductible		Med. co-pay		
		Co-insurance		Other		
<input type="checkbox"/> Medicare Supplemental Plan/ Medigap		Premium		Med. visit co-pay		
		Deductible		Med. co-pay		
		Co-insurance		Other		
<input type="checkbox"/> Veterans Insurance						
<input type="checkbox"/> Dental Insurance						
<input type="checkbox"/> AIDS Drug Assistance Program						
BENEFIT TYPE		BENEFIT INFORMATION				
<input type="checkbox"/> Insurance Assistance Program						

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Client DOB:

INSURANCE	
<input type="checkbox"/> Michigan Dental Program	
Do you carry insurance cards with you and provide them to your medical provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you need any assistance with your health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Comments:	

DHS OFFICE (ADDRESS/PHONE)	DHS WORKER	OUTSTANDING DHS NEEDS

Legal	
Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes	This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need
If there are changes and/or this is a new/continuing need, then updates must be provided below.	
Have you ever been convicted of a crime? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Have you ever been to jail/prison? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
How have you met your health needs in jail/prison?	
Do you currently have any of the following legal issues? <input type="checkbox"/> Outstanding warrants <input type="checkbox"/> Civil charges <input type="checkbox"/> Criminal charges <input type="checkbox"/> Probation <input type="checkbox"/> Parole <input type="checkbox"/> Child protective custody <input type="checkbox"/> Family court	If yes, explain:
Parole/Probation Officer	Are you required to register? <input type="checkbox"/> Yes <input type="checkbox"/> No

Do you need legal assistance with the following:		Comments:
<input type="checkbox"/> Immigration	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Client Name:

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Client DOB:

Legal		
<input type="checkbox"/> Power of attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In place	
<input type="checkbox"/> Medical power of attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In place	
<input type="checkbox"/> Guardianship	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In place	
<input type="checkbox"/> Will	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In place	
<input type="checkbox"/> Living will	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In place	
<input type="checkbox"/> Permanency Planning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In place	
<input type="checkbox"/> Burial arrangements	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In place	
<input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In place	
Comments:		

Cultural/Linguistics			
Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need	
If there are changes and/or this is a new/continuing need, then updates must be provided below.			
What is your preferred language?		<input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write	
		<input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write	
Do you need a translator or interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you hearing impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you need a sign interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you able to complete forms independently? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you prefer a medical provider of a particular: Gender? <input type="checkbox"/> Yes <input type="checkbox"/> No Age? <input type="checkbox"/> Yes <input type="checkbox"/> No Other requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:		
Do you have any beliefs prohibiting: <input type="checkbox"/> Taking any medication? <input type="checkbox"/> Blood Transfusion? <input type="checkbox"/> Participating in medical research? <input type="checkbox"/> Any specific medical procedure? <input type="checkbox"/> Other:	If any checked, explain:		
Is there anything else regarding your culture/beliefs your health care providers should be aware of? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe:		

Comments:

Client Name:

Client DOB:

HIV Knowledge and Health Literacy

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes	This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need
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If there are changes and/or this is a new/continuing need, then updates must be provided below.

What is HIV?

What is AIDS?

You can get HIV from the following:

Sharing needles and/or works	<input type="checkbox"/> True <input type="checkbox"/> False	Oral sex	<input type="checkbox"/> True <input type="checkbox"/> False
Tattoos	<input type="checkbox"/> True <input type="checkbox"/> False	Mosquitoes	<input type="checkbox"/> True <input type="checkbox"/> False
Piercing body parts	<input type="checkbox"/> True <input type="checkbox"/> False	Kissing	<input type="checkbox"/> True <input type="checkbox"/> False
Vaginal sex	<input type="checkbox"/> True <input type="checkbox"/> False	Breastfeeding	<input type="checkbox"/> True <input type="checkbox"/> False
Anal sex	<input type="checkbox"/> True <input type="checkbox"/> False	Shaking hands	<input type="checkbox"/> True <input type="checkbox"/> False

What is a CD4 count and a viral load measure?

Why is it important to monitor CD4 count and viral load?

(For MCM to answer) Based on the above information, rate the client's level of HIV knowledge:
 Excellent Very Good Good Fair Poor

How often do you need help reading the following:

Written information about how to take care of yourself?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
Written information about how to take your medications?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
Written information about medication side effects?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
Appointment notifications and reminders?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
Treatment information from your dietician, MCM, or mental health/substance abuse counselor?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never

How often do you need help with the following:

Figuring out the time to take medications?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
Figuring out if you need to eat with medications?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
Understanding your medical provider when he/she talks about your health?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
Being able to effectively communicate your needs to your medical provider?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
Being able to effectively negotiate your health care?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
Discussing your insurance with your clinic's billing office?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
Discussing your benefits with your insurance plan?	
Filling out your medical forms by yourself?	

Client Name:

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Client DOB:

HIV Knowledge and Health Literacy

Comments:

Client Name:

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Client DOB:

Health and Medical Care

Since last (re)assessment, there has been:

No changes Changes

This is a: New Need Continuing Need

Not a need

If there are changes and/or this is a new/continuing need, then updates must be provided below.

MEDICAL APPOINTMENTS

Are you in medical care? Yes No If yes, complete chart below:

TYPE OF PROVIDER	NAME	CLINIC NAME ADDRESS/PHONE	LAST APPOINTMENT	NEXT APPOINTMENT
Primary Care			<input type="checkbox"/> Kept <input type="checkbox"/> Missed <input type="checkbox"/> Rescheduled	
Infectious Disease			<input type="checkbox"/> Kept <input type="checkbox"/> Missed <input type="checkbox"/> Rescheduled	
Other:			<input type="checkbox"/> Kept <input type="checkbox"/> Missed <input type="checkbox"/> Rescheduled	
Other:			<input type="checkbox"/> Kept <input type="checkbox"/> Missed <input type="checkbox"/> Rescheduled	

How often are your appointments with the ID provider?

More often than once a month Once every month Once every 2-3 months Once every 6 months

Other:

Do you schedule your own appointments?

Yes No

Has your ID provider told you that your access to care is in jeopardy due to missed appointments?

Yes No

What are some reasons for missed appointments?

What will make it easier for you to keep your medical appointments?

How do you keep track of medical visits, discussions about health, labs, etc.?

Are there health issues you feel you cannot discuss with your provider?

Yes No

What is the level of HIV care you receive from your medical provider? (Identify barriers related to provider-client relationship, clinic practices and services, etc.)

Comments:

HEALTH STATUS

Since last (re)assessment, there has been:

No changes Changes

This is a: New Need Continuing Need

Not a need

If there are changes and/or this is a new/continuing need, then updates must be provided below.

Date of HIV diagnosis

Mode of transmission

How would you describe your health? (Discuss if health has improved/stayed same/declined; any significant changes in lab work; any concerns with health; if medications are working.)

Client Name:

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Client DOB:

HEALTH STATUS					
Viral Load	Date	Next Scheduled	CD4 count	Date	Next scheduled
Within the last month, have you experienced any of the following symptoms?					
<input type="checkbox"/> Thrush	<input type="checkbox"/> Headache	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Memory loss
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Spiking Fevers
<input type="checkbox"/> Other:					
TB status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		TB Test Date		Chest X-ray Date	
Currently on TB treatment? (include on meds list) <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you adherent? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of completion	
Have you completed TB treatment in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No				Date of completion	
Hepatitis status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		Type of Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	Currently on Hepatitis treatment? (include on meds list) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Vaccines			Date(s) of completion		
<input type="checkbox"/> MMR (Measles, Mumps, Rubella)					
<input type="checkbox"/> Tdap (Tetanus, Diphtheria, Pertussis; once every 10 years)					
<input type="checkbox"/> Hepatitis A					
<input type="checkbox"/> Hepatitis B					
<input type="checkbox"/> Flu (once a year)					
<input type="checkbox"/> Pneumovax (Pneumonia; repeat every 5 years)					
<input type="checkbox"/> Other:					
Have you ever been diagnosed with or treated for an opportunistic infection? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete chart below:					
OPPORTUNISTIC INFECTION		DIAGNOSED	DATE OF DIAGNOSIS	TREATMENT RECEIVED	TREATMENT COMPLETED
Candidiasis (Thrush) of bronchi, trachea, esophagus, or lungs		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cytomegalovirus disease		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cytomegalovirus retinitis		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Encephalopathy		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Herpes simplex virus		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Histoplasmosis		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Invasive cervical cancer		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kaposi Sarcoma		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lymphoma		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mycobacterium Avium Complex		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumocystis carinii pneumonia (PCP)		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia, recurrent		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Toxoplasmosis		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wasting syndrome		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been hospitalized for any illness (including an OI)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete chart below:					
DATE	HOSPITAL		REASON FOR HOSPITALIZATION		

Client Name:

Client DOB:

HEALTH STATUS		

Besides HIV, do you have any other conditions, illness, or diseases? Yes No If yes, complete chart below:

HEALTH CONDITION	DATE OF DIAGNOSIS	TREATMENT RECEIVED	TREATMENT COMPLETED
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Comments:

SEXUAL AND REPRODUCTIVE HEALTH

Since last (re)assessment, there has been:
 No changes Changes
 This is a: New Need Continuing Need
 Not a need

If there are changes and/or this is a new/continuing need, then updates must be provided below.

What sex were you assigned at birth? Male Female Other:

Have you experienced any sexual or reproductive surgeries? Yes No
 If yes explain:

What are your thoughts on family planning? Yes No
 Is family planning in place?
 Yes No

Describe what you know about HIV and pregnancy:

How frequently do you get tested for STIs? Yes No
 When was your last STI test?
 Do you believe you currently have an STI? Yes No

Have you ever been diagnosed with a sexually transmitted infection? Yes No If yes, complete chart below:

SEXUALLY TRANSMITTED INFECTION	DATE OF DIAGNOSIS	TREATMENT RECEIVED	TREATMENT COMPLETED
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Client Name:

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Client DOB:

SEXUAL AND REPRODUCTIVE HEALTH

		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments: 			

WOMEN'S HEALTH

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need	
If there are changes and/or this is a new/continuing need, then updates must be provided below.			
Date of last OB/GYN exam	Date of last Vaginal Pap	Date of last Anal Pap	Date of last mammogram
Results of last Vaginal Pap		Results of last Anal Pap	Results of last mammogram
Did any of the test results require follow-up? If so, did you follow-up?			
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated # of weeks	Receiving prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No	On antiretroviral therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever given birth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of times	Explain any pregnancy related complications:	
Do you believe you had HIV during your previous pregnancies? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe your experience:		
Are you currently breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Other women's health issues/comments:			

MEN'S HEALTH

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need	
If there are changes and/or this is a new/continuing need, then updates must be provided below.			
Date of last prostate exam	Date of last testicular exam	Date of last Anal Pap	
Results of last prostate exam	Results of last testicular exam	Results of last Anal Pap	
Did any of the test results require follow-up? If so, did you follow-up?			
Other men's health issues/comments:			

Client Name:

13

Client DOB:

TRANSGENDER HEALTH

Since last (re)assessment, there has been:

 No changes ChangesThis is a: New Need Continuing Need Not a need

If there are changes and/or this is a new/continuing need, then updates must be provided below.

Are you on hormone replacement therapy?

 Yes No

Date hormone replacement therapy started

How do you access hormone replacement therapy?

Name of prescribing provider/clinic

If not through prescribing provider, is PCP/HIV care provider aware? Yes No

Other transgender health issues/comments:

ORAL HEALTH

Since last (re)assessment, there has been:

 No changes ChangesThis is a: New Need Continuing Need Not a need

If there are changes and/or this is a new/continuing need, then updates must be provided below.

Do you receive regular dental care? Yes No If yes, complete chart below:

TYPE OF PROVIDER	NAME	CLINIC NAME ADDRESS/PHONE	LAST APPOINTMENT	NEXT APPOINTMENT
Dental			<input type="checkbox"/> Kept <input type="checkbox"/> Missed <input type="checkbox"/> Rescheduled	
Other:			<input type="checkbox"/> Kept <input type="checkbox"/> Missed <input type="checkbox"/> Rescheduled	

What are some reasons for missed appointments?

How often are your appointments with the dental provider?

 More often than once a month Once every month Once every 2-3 months Once every 6 months

Other:

Do you schedule your own appointments? Yes No

What will make it easier for you to keep your dental appointments?

What is the level of care you receive from your dental provider? (Identify barriers related to lack of access, fear, etc.)

Comments:

VISION HEALTH

Since last (re)assessment, there has been:

 No changes ChangesThis is a: New Need Continuing Need Not a need

If there are changes and/or this is a new/continuing need, then updates must be provided below.

Do you receive regular vision care? Yes No If yes, complete chart below:

TYPE OF PROVIDER	NAME	CLINIC NAME ADDRESS/PHONE	LAST APPOINTMENT	NEXT APPOINTMENT
------------------	------	------------------------------	------------------	------------------

Client Name:

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Client DOB:

VISION HEALTH

Vision			<input type="checkbox"/> Kept <input type="checkbox"/> Missed <input type="checkbox"/> Rescheduled	
Other:			<input type="checkbox"/> Kept <input type="checkbox"/> Missed <input type="checkbox"/> Rescheduled	
What are some reasons for missed appointments?				
How often are your appointments with the vision care provider?				
<input type="checkbox"/> More often than once a month <input type="checkbox"/> Once every month <input type="checkbox"/> Once every 2-3 months <input type="checkbox"/> Once every 6 months Other:				
Do you schedule your own appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What will make it easier for you to keep your vision care appointments?				
What is the level of care you receive from your vision care provider? (Identify barriers related to lack of access, fear, etc.)				
Comments:				

Medication Adherence

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need		
If there are changes and/or this is a new/continuing need, then updates must be provided below.				
Are you taking any prescription or over the counter medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, complete the MEDICATION CHART.</i>				
Are you taking herbal or alternative medications/therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, complete chart below:</i>				
HERBAL	ALTERNATIVE	NAME OF MEDICATION/THERAPY	PROVIDER	PURPOSE
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
Is your ID provider aware of these herbal/alternative medications/therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No				
How do you receive your medications? <input type="checkbox"/> Pick up at pharmacy <input type="checkbox"/> Delivery <input type="checkbox"/> Other:			Do you have difficulty filling/refilling your medications? <div style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	

If yes, what type of problems?

Name of Primary Pharmacy		Name of Secondary Pharmacy		
Where do you store your medications?	Do you believe your medications are stored safely? <div style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	Do you hide your medications from others? <div style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>		

Client Name:

15

Client DOB:

Medication Adherence

How do you take your medications? <input type="checkbox"/> Given by another person <input type="checkbox"/> Self-administered <input type="checkbox"/> Other:		Rate your ability to take your medication as prescribed over the last 7 days: <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
Have you missed doses in:		What do you do when you miss a dose?			
24 hours: <input type="checkbox"/> Yes <input type="checkbox"/> No	How many?				
3 days: <input type="checkbox"/> Yes <input type="checkbox"/> No	How many?				
7 days : <input type="checkbox"/> Yes <input type="checkbox"/> No	How many?				
1 month : <input type="checkbox"/> Yes <input type="checkbox"/> No	How many?				
What are some reasons for missing doses?					
<input type="checkbox"/> I get too busy	<input type="checkbox"/> I forget	<input type="checkbox"/> I feel overwhelmed			
<input type="checkbox"/> I feel depressed	<input type="checkbox"/> I am tired of taking pills	<input type="checkbox"/> I run out of pills			
<input type="checkbox"/> I have too many pills	<input type="checkbox"/> I can't afford medications	<input type="checkbox"/> I get side-effects			
<input type="checkbox"/> I just don't want to take them	<input type="checkbox"/> I have problems swallowing	<input type="checkbox"/> I need breaks from taking pills			
<input type="checkbox"/> I am away from home when it is time to take my pills	<input type="checkbox"/> There is a change in my routine	<input type="checkbox"/> I have trouble remembering to eat or not to eat with pills			
<input type="checkbox"/> Other:					
Are you experiencing difficulty with any of the following?					
<input type="checkbox"/> Understanding instructions for medications		<input type="checkbox"/> Not taking proper # of medications			
<input type="checkbox"/> Taking medications prescribed for others		<input type="checkbox"/> Not taking medications on time			
<input type="checkbox"/> Other:					
Do you experience side effects with HIV medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete chart below to identify the severity.					
SIDE EFFECTS	SEVERE	SOMEWHAT	A LITTLE	NOT AT ALL	NOT SURE
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad Dreams or confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taste alteration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discoloration of skin or nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness /tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drowsiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What have you done about the side effects?					
What will make it easier for you to take your medications?					
Comments:					

Client Name:

16

Client DOB:

Food and Nutrition

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need	
If there are changes and/or this is a new/continuing need, then updates must be provided below.			
Current Weight		Current Height	
Describe your appetite. (Include # of meals per day; type of food)			
Are you experiencing any physical problems that make it difficult to eat? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Mouth problems	<input type="checkbox"/> Food allergies	<input type="checkbox"/> Nausea	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Swallowing problems	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Taste Alteration	<input type="checkbox"/> Other:
Do you have any dietary restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what are they?		
Have you gained or lost a significant amount of weight in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe the reasons for the significant weight gain/loss.		
Are you being treated for a weight gain or loss problem? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is the treatment?		
Are you receiving medical nutrition therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Dietitian		
Do you have access to enough food? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, explain:		
Are you taking nutritional or vitamin supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which supplements?	If yes, who prescribed them?	
Comments:			

Activities of Daily Living

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need			
If there are changes and/or this is a new/continuing need, then updates must be provided below.					
Check level of functioning for each activity of daily living:					
FUNCTION	INDEPENDENT	NEEDS HELP	DEPENDENT	DOES NOT DO	NOT SURE
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FUNCTION	INDEPENDENT	NEEDS HELP	DEPENDENT	DOES NOT DO	NOT SURE
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Client Name:

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Client DOB:

Activities of Daily Living

Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a physical disability that impacts your daily activities? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:				
What medical devices/durable medical equipment do you need?					
Are you receiving home care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of nurse/home care agency:		Type of service: <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Chore services <input type="checkbox"/> Physical/occupational therapy <input type="checkbox"/> Other:		
If you are currently not enrolled, are you in need of an evaluation for home care services? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Comments:					

Mental Health

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need	
If there are changes and/or this is a new/continuing need, then updates must be provided below.			
How is your general mood/emotional health?			
How do you cope with HIV? What has been the hardest challenge in living with HIV?			
What symptoms are you been experiencing?			
<input type="checkbox"/> Sleep problems	<input type="checkbox"/> Dread/fear	<input type="checkbox"/> Feeling hopeless	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Sad Mood	<input type="checkbox"/> Hard time remembering	<input type="checkbox"/> Crying	<input type="checkbox"/> Anger
<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Reliving past events	<input type="checkbox"/> Irritability	<input type="checkbox"/> Worried thoughts
<input type="checkbox"/> Feeling bad about yourself	<input type="checkbox"/> Relationship/family problems	<input type="checkbox"/> Feeling nervous	<input type="checkbox"/> Distress/worry about HIV
<input type="checkbox"/> Concerned about the future	<input type="checkbox"/> Seeing or hearing things others do not	<input type="checkbox"/> Worry about medical condition(s)	<input type="checkbox"/> Having the same thoughts repeatedly
<input type="checkbox"/> Decreased interest in things you usually enjoy	<input type="checkbox"/> Other:		
Have you had thoughts about hurting yourself, taking your life, or harming someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No	How recently?		
Describe the circumstances (assess ideation, plan, intent, names of people client wants to harm).			
Have you ever attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No	What happened?		

Client Name:

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Client DOB:

Mental Health

Do you feel unsafe in any current relationship or place of residence?
 Yes No

If yes, explain:

Do you have a history of mental health diagnoses? Yes No If yes, complete chart below:

MENTAL HEALTH CONDITION	DATE OF DIAGNOSIS	COMMENTS

Have you ever sought treatment for mental health issues? Yes No If yes, complete chart below.
 Examples of modalities: inpatient hospitalization; outpatient individual/group therapy; family counseling; crisis interventions

PAST DATES	TREATMENT MODALITY	TREATMENT FACILITY	COMPLETED?
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing

List information for the most recent/current mental health provider(s).

TYPE OF PROVIDER	NAME	CLINIC NAME ADDRESS/PHONE	LAST APPOINTMENT	NEXT APPOINTMENT
Therapist/Counselor			<input type="checkbox"/> Kept <input type="checkbox"/> Missed <input type="checkbox"/> Rescheduled	
Group Counselor			<input type="checkbox"/> Kept <input type="checkbox"/> Missed <input type="checkbox"/> Rescheduled	
Psychiatrist				

Client Name:

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Client DOB:

Mental Health

			<input type="checkbox"/> Kept <input type="checkbox"/> Missed <input type="checkbox"/> Rescheduled	
Other:			<input type="checkbox"/> Kept <input type="checkbox"/> Missed <input type="checkbox"/> Rescheduled	
How often are your appointments with mental health provider(s)? <input type="checkbox"/> Once a month <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Once a week Other:				
What are some reasons or barriers that prevented you from maintaining mental health treatment?				
Do you schedule your own appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What will make it easier for you to keep your mental health appointments?				
What is the level of care you receive from your mental health provider?				
Comments:				

Substance Use and Treatment

Since last (re)assessment, there has been:

No changes Changes

This is a: New Need Continuing Need

Not a need

If there are changes and/or this is a new/continuing need, then updates must be provided below.

Do you have a history of substance use/abuse? Yes No If yes, complete chart below.

SUBSTANCE	AMOUNT/FREQUENCY (daily, weekly, monthly)	ROUTE (oral, nasal, smoke, IVDU)	DATE OF LAST USE
Nicotine/Tobacco			
Alcohol			
Marijuana			
Cocaine			
Crack			
Prescription drugs			
Heroin			
Hallucinogens			
Crystal Meth			
Inhalants			
LSD/PCP			
Other:			
Other:			
Other:			

Describe history of substance use/abuse. (Drug of choice, age started, triggers, etc.)

Have you ever sought treatment for substance use/abuse? Yes No If yes, complete chart below.

PAST DATES	TREATMENT MODALITY	TREATMENT FACILITY	COMPLETED?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

What are some reasons or barriers that prevented you from completing treatment?

Are you currently in substance abuse treatment? Yes No If yes, complete chart below.

Client Name:

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Client DOB:

Substance Use and Treatment

TREATMENT MODALITY	DATE	COMMENTS
Stop smoking program		
Methadone maintenance		
Detox		
Inpatient substance use program		
Outpatient substance use program		
AA/NA or other self-help group		
TREATMENT PROGRAM (ADDRESS/PHONE)	TREATMENT COUNSELOR	DATE WHEN TREATMENT ENDS
Does your substance use prevent you from going to medical appointments and/or taking your medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you in recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No		What has been your longest period of abstinence?
What has helped you remain in recovery?		
What are your relapse triggers?		
If client is actively using substances, answer the following questions:		
If you inject substances, describe how you keep yourself safe from further injection-related harm?		
Do you utilize a needle exchange? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a history of overdosing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are harm reduction methods being used? <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, are you interested in a referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	(Alcohol use) Do you have a history of Delirium Tremens (DT)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like assistance to connect with Partner Services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you interested in stopping drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like a referral to substance use treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you interested in learning more about overdose prevention and/or harm reduction? <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:		

HIV Prevention and Risk Reduction

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes		This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need
If there are changes and/or this is a new/continuing need, then updates must be provided below.		
Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many sexual partners have you had within the past 2 months?	How do you meet your sexual partners? (Online, bathhouses, clubs, friends, etc.)
What are the genders of your sexual partners? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other:	Describe how you negotiate safer sex for yourself and your partners. (Condoms, viral suppression, serosorting, etc.)	
Are you currently virally suppressed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do your HIV negative partners have access to PrEP prevention supplies? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe how you negotiate PrEP with your partners:

Client Name:

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Client DOB:

HIV Prevention and Risk Reduction

What HIV/STD prevention methods do you use when having sex? <input type="checkbox"/> Condom <input type="checkbox"/> Dental dam <input type="checkbox"/> Saran Wrap <input type="checkbox"/> Latex gloves <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other:	Do you have access to barrier methods (e.g. condoms)? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(For MCM to answer)</i> Can client describe the proper use of condoms?
I may not use barrier methods when:		
<input type="checkbox"/> When I am sexually excited	<input type="checkbox"/> When I feel angry or upset	<input type="checkbox"/> When I am with a new partner
<input type="checkbox"/> When I am the top	<input type="checkbox"/> When I am the bottom	<input type="checkbox"/> When I am drinking and/or high
<input type="checkbox"/> When I feel bad about myself	<input type="checkbox"/> Condoms don't feel good	<input type="checkbox"/> When I am seeking drugs/money
<input type="checkbox"/> When there's not much risk	<input type="checkbox"/> When I'm undetectable	<input type="checkbox"/> When I'm not expecting sex
<input type="checkbox"/> When my partner pressures me to not use condoms	<input type="checkbox"/> When my partner(s) are HIV-positive	<input type="checkbox"/> Other:
How often do you disclose your HIV status with sexual partners?	Is there anything about safer sex or sexual risk that you want to know more about? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe:
<i>(For MCM to answer)</i> Is the client aware of the Michigan HIV Disclosure law? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, did the MCM make client aware of the law? <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like assistance to connect with Partner Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your partner(s) been tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you need assistance to access HIV testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:		

Social Support and Spirituality

Since last (re)assessment, there has been: <input type="checkbox"/> No changes <input type="checkbox"/> Changes	This is a: <input type="checkbox"/> New Need <input type="checkbox"/> Continuing Need <input type="checkbox"/> Not a need
If there are changes and/or this is a new/continuing need, then updates must be provided below.	
What do you do to socialize?	
What are your interests?	
What type of support system do you have? <input type="checkbox"/> None <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Religious group <input type="checkbox"/> Support group <input type="checkbox"/> Neighbors <input type="checkbox"/> Social Media <input type="checkbox"/> Other:	Do you believe you have an adequate support system? <input type="checkbox"/> Yes <input type="checkbox"/> No

Have you told anyone about your HIV status? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete chart below:		
NAME OF SUPPORT PERSON	RELATIONSHIP	SUPPORTIVE OF YOU TAKING MEDICATIONS AND GOING TO MEDICAL APPOINTMENTS?
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Client Name:

23

Client DOB:

Social Support and Spirituality

		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
Who helps you when you are seriously ill?		
Do you need help to disclose your HIV status? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who?	
Is religion/faith/spirituality important to you? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:	
List 3 strengths or positive areas in your life.		
How do these strengths help you deal with your diagnosis?		
(For MCM to answer) List 3 strengths you have identified.		
Comments:		

Summary of Client Needs (Per CM)

Summary of Client Needs (Per Client)

CM Signature	CM Name	Date
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Medication CHART

Include all medications on this chart.

NAME OF MEDICATION	PURPOSE OF MEDICATION	PRESCRIBER (if applicable)
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Client Name:

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Client DOB:

