



Oregon Department of Human Services
Public Health Division
HIV/STD/TB Program
HIV Care and Treatment Program

Psychosocial Screening

Required form

"Confidential — this form must always be saved on a secure network accessible only by Ryan White funded staff."

Client name: _____ Client #: _____ CM initial: _____ Date: _____
 Initial screening Annual re-screening Date of screening: _____

Mental health screening

If "no" to any of the following questions and client reports memory loss, refer for mental health evaluation.

- Does client know where he/she is? Yes No
 Does client know today's date? Yes No
 Does client know why he/she is here? Yes No

Does the client report any of the following a problem in the past year?

- Depression Anxiety Eating patterns Withdrawal from others
 Forgetfulness Delusions Sleep patterns Thoughts or actions of harm to self or others*
 Insomnia Confusion Feeling isolated (*Self harm screening)

Has client ever had a mental health (MH) diagnosis? Yes No

If yes, describe: _____

Does client have a current MH diagnosis? Yes No

If yes, describe: _____

Has client ever been hospitalized for a MH condition? Yes No

If yes, describe: _____

Has client ever been prescribed medication for a MH condition? Yes No

If yes, what conditions? _____

Reasons for discontinuing MH medication(s): _____

Is client taking medications for a MH condition now? Yes No

If yes, what medication(s)? _____

Is client currently (last 3 months) enrolled in a treatment program? Yes No

If yes, describe: _____

How troubled have you been in the past three months with any mental health problems? (*check one*)

Not at all	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	Extremely
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Do you think that counseling or a support group would be helpful? (*check one*)

Not at all	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	Extremely
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Plan: Refer for mental health assessment Yes No

Provider referred to: _____

Comments/details/other: _____

Mental health treatment options (*complete for CAREWare*):

- In treatment Waiting list Refused treatment Completed treatment Dropped out
 Pre-treatment process No active treatment or counseling
 Other: _____

***Self harm screening**

If client has had suicidal thoughts and IF agency has written policy on suicide in place, ask:

- Has client ever attempted to hurt (*check one*) self or others in past? Yes No
- Does client currently have thoughts of hurting (*check one*) self or others? Yes No
- Does the client have a specific plan? Yes No
- Does the client have the means to carry out the plan? Yes No

Comments: _____

Domestic safety

Oregon has a law that requires us to report child/elder abuse/neglect. This is called mandatory reporting. If you are younger than 18 or older than 65 years of age, based on your response to the next three questions, I may be required to report your situation.

- Has your partner/ex-partner ever physically hurt or threatened to hurt you? Yes No Current
- Do you feel controlled by your partner or feel you are in danger? Yes No Current
- Has your partner forced you to have sex or refused to practice safe sex? Yes No Current

Comments: _____

Substance use/addiction history and screening

Substance use/abuse/addiction	Use P = past; C = current	Amount	Frequency daily/weekly monthly	Duration <1 yr; 1-2 yr; >2 yr	Last use <1 mo; 1-6 mo; 6 mo - 2 yr; >2yr	Problem for client? X = yes	Others say a problem? X = yes	Wants treatment? X = yes
Gambling						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine (cigs/chew)						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical marijuana with card						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speed/meth						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rx medications						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Ever had A&D related justice contacts? Yes No Past year
- Ever had DUI? Yes No Past year
- Ever had a blackout? Yes No Past year
- A&D related ER or hospitalizations? Yes No Past year
- Ever been in treatment or support program? Yes No Past year

Describe: _____

Do you think that addiction counseling or a support group would be helpful? (*check one*)

Not at all	Extremely
<input type="checkbox"/> 1	<input type="checkbox"/> 10

Client name: _____ Client#: _____ CM initial: _____ Date: _____

Plan: Refer for substance abuse treatment Yes No

Provider referred to: _____

Comments/details/other: _____

Risk assessment

Currently in intimate relationship? Yes No If yes, how long? _____

Number of sexual partners in past year: 0 1 2-3 4-10 10+

Type of partners: Other sex Same sex Both sexes Anonymous encounters

Type of sex: Vaginal Oral Anal

Does client inject drugs with needles? Yes No

Does client share needles? Yes No

Have all of client's sexual/needle sharing partners been informed of client's HIV status? Yes No

In the past 12 months

Did any of the client's partners have sex with another person while they were still in a relationship with the client?

Yes No Don't know

Has the client been told they have a sexually transmitted disease?

Yes No Don't know

If yes, which ones? _____

Has any of the client's sex partners been told they had a sexually transmitted disease? Yes No Don't know

If yes, which ones? _____

How does client protect themselves and their partners from infection?

Abstinence One partner Condoms Clean needles and works Oral, not anal

Top anal, not bottom Other: _____

How often does client and/or partner engage in these strategies? (*check one*)

<i>Never</i>										<i>Always</i>
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	

Harm reduction

What are some things that you are doing that put you at risk? _____

Do you know some ways to reduce the risk of transmission? _____

What is one thing you could do to reduce the risk? _____

How likely is it that you will be able to do this? (*check one*)

<i>Not likely</i>										<i>Very likely</i>
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	

Plan: Refer to Supporting Health Options for Prevention (SHOP) 1-877-795-7700 Yes No

Comments/details/other: _____

Summary (complete for entry into CAREWare after screening done)

Mental health history:

None Unknown Yes, active within last 3 months Yes, but not active with last 3 months

Substance abuse history:

None Unknown Yes, active within last 3 months Yes, but not active with last 3 months

Client name: _____

Client#: _____

CM initial: _____

Date: _____

Social support system

Current spouse or partner: _____ Is partner aware of client's HIV status? Yes No

What other support systems does client have available to them?

- Family, local Family, distant Church Support groups
 Friends, local Friends, distant Clubs Other: _____

Comments: _____

Signature and credentials: _____ Date: _____