Colorado Health Network Medical Clinic

Intake- H (Updated 12/12/2019)

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 ____

County ____ ☐ Homeless ☐ Mail at CHN Office

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:**	**Discreet?**	**NO CALL**	**Message**
Phone # ____________	________	**Yes | No**	________	**Yes | No**
Phone # ____________	________	**Yes | No**	________	**Yes | No**
Email ____________	________	**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

Trans-oriented

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?
Name	Relationship	Gender	Ethnicity	Date of Birth	Custody?
Name	Relationship	Gender	Ethnicity	Date of birth	Custody?

Relationship Status:
(Please Circle One)
Single
Married
Committed Relationship
Polyamorous Relationship
Separated
Divorced
Widowed
Client is a Child
Write in:______________________________

☐ Non-Monogamous

Living Situation:
(Circle one)
Apartment
House/Condo
Shelter
Friend's Home
With Family
Homeless
Group Facility
Couch Surfing

Subsidized?
Section 8
HOPWA Unit
TBRA
Other

Childcare Assistance?
(Please Describe Needs)

Education/Employment:

Education:
Highest Grade Completed:
Pre-HS   High School
College   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:_______________________________________

Insurance:

Insurance

(Select ALL that Apply)

_____Medicaid _____Medicare A _______ Medicare B _____VA _____VA

_____QMB _____Private, Insurance (Carrier:______________________________) ____None

____ADAP ____ PHIP ____ Gilead Advancing Access _______ Gilead Co-Pay Card

Primary on Insurance:___________________________

Medicaid/Medicare/Private insurance #:____________________

Dental Insurance:______________________________

Criminal Record

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**

Trauma History:

Has anyone you know ever hit, kicked, slapped, or sought to mentally mistreat you?

Current Adulthood Past Adulthood Childhood Other

(Please describe to the degree that you are comfortable)

____

____

____

Mental Health:

Mental Health Care/Care Team:

Clinic	Contact/Title	Phone	Type

Diagnosis:____

____

____

Would you be interested in a counselling referral?

Yes | No

____

(For what presenting issues? Please list.)

Health

Medical Care / Care Team:

Clinic	Contact/Title	Phone	Type

Health Cont.

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?

____

____

Health Cont.

HIV Status:
(Chose One)

___HIV Symptomatic

___HIV Asymptomatic

___AIDS Symptomatic

___AIDS Asymptomatic

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):_________

Symptoms/Opportunistic Infection:_______________________________

____

____

____

____

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

Medication	Type	Start Date

Client Treatment Status:
Naïve Experienced Never been on treatment

Side Effect:

____

____

Adherence Difficulties:

____

____

Doses Missed Past Seven (7) Days:_______________

Reason Not On Meds:

____

____

Sexual Health

How do you believe you acquired 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**

Sexual Health Cont.

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
_______ Syphilis
_______ Anal Warts
_______ Genital Warts
_______ Scabies
_______ Crabs
_______ Pelvic Inflammatory Disease
_______ Genital Herpes
_______ Chancroid
_______ Non-Gonoccal (NGU)
_______ Proctatitis/ Proctocolitis
_______ Epididymitis
_______ Trichomoniasis
_______ Cervicitis
_______ Lymphogranuloma Vernerum

Have you ever been treated for Hepatitis C?
Yes _____ *No* _____

Substance Use:

***Have you smoked cigarettes or used other tobacco products in the past 3 years? (Includes Vaping)** **Yes | No**
On average, how many days a week do you drink alcohol? _______________
On a typical day when you drink, how many drinks do you have? _______________
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)
☐ Psilocybin (Magic Mushrooms)
☐ Other: _______________

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

SBIRT Code:______________________________

Code 1 (Negative)-1001
Code 2 (Positive)-1002
Code 3 (Refused Screen)-1003
Code 4 (+ Screen and Referred)-1004
Code 5 (Patient Quit Substance Use)-1005

Men>65 & All Women (3/day or 7/week) **Men≤65 (4/day or 14/week)**

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?

____

____

____