

Colorado Health Network Medical Clinic

Intake- P (Updated 121/12/2019)

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:

Phone # _____

Phone # _____

Email _____

Discreet?

Yes | No

Yes | No

Yes | No

NO CALL

Message

Yes | No

Yes | No

Yes | No

EMERGENCY CONTACT INFORMATION:

 Name Relationship Phone Discreet?

 Name Relationship Phone Discreet?

 Name Relationship Phone Discreet?

Client Demographics:

Gender Male Female Trans*(MTF) Trans*(FTM) Gender Queer Gender Non-Conf.	Ethnicity Non-Hispanic Hispanic (Specify): Mexican Puerto Rican Cuban Other Hispanic	Sexual Orientation Heterosexual Gay Lesbian Bisexual Pansexual Trans-oriented Asexual Undisclosed	Religious Affiliation: Language(s): _____ (Speak Read Write) _____ (Speak Read write)
Sex Assigned at Birth Male Female Intersex	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		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: _____

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

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

Clinic Contact/Title Phone Type

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.

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) (blood components, or tissue)
- Other (Please explain)

Have you ever tested positive for?

- Hepatitis B
- Pelvic Inflammatory Disease
- Hepatitis C
- Trichomoniasis
- Gonorrhea
- Scabies
- Chlamydia
- Crabs
- Genital Herpes
- Epididymitis
- Genital Warts
- Cervicitis
- Anal Warts
- Proctatitis/ Proctocolitis
- Chancroid
- Lymphogranuloma Venerum
- Syphilis
- Non-Gonoccal (NGU)

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

Current Medication:

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

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

Client Treatment Status:

Naïve

Experienced

Never been on PrEP

Side Effect:

Adherence Difficulties:

Doses Missed Past Seven (7) Days: _____

Reason Not On Meds:

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)

- | | | |
|--|--|---|
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Amphetamine (Adderall) | <input type="checkbox"/> Buprenorphine (Suboxone) |
| <input type="checkbox"/> Cocaine or Crack | <input type="checkbox"/> Methylphenidate (Ritalin) | <input type="checkbox"/> Methadone |
| <input type="checkbox"/> Methamphetamine | <input type="checkbox"/> Alprazolam (Xanax) | <input type="checkbox"/> Carisoprodol (SOMA) |
| <input type="checkbox"/> Inhalants/ Nitrites (poppers) | <input type="checkbox"/> Clonazepam (Klonopin) | <input type="checkbox"/> Psilocybin (Magic Mushrooms) |
| <input type="checkbox"/> Heroin | <input type="checkbox"/> Tramadol | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> LSD | <input type="checkbox"/> Diazepam (Valium) | |
| <input type="checkbox"/> MDMA (ecstasy/ Molly) | <input type="checkbox"/> Zolpidem (Ambien) | |
| <input type="checkbox"/> DMT | <input type="checkbox"/> Lorazepam (Ativan) | |
| <input type="checkbox"/> Ketamine (special K) | <input type="checkbox"/> Hydrocodone (Vicodin) | |
| <input type="checkbox"/> Viagra, Levitra, Cialis or other sex enhance drug | <input type="checkbox"/> Morphine | |
| <input type="checkbox"/> Hormones | <input type="checkbox"/> Oxycodone | |
| <input type="checkbox"/> Steroids | | |

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

SBIRT Code: _____

Code 1 (Negative)-1001

Code 3 (Refused Screen)-1003

Code 5 (Patient Quit Substance Use)-1005

Code 2 (Positive)-1002

Code 4 (+ Screen and Referred)-1004

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?
