Appointment Date: _____ Patient ID #_____

☐P ☐RW ☐C ☐ Dental ☐Medical ☐NP ☐EMX ☐WL☐Retention

Colorado Health Network Clinical Services

Patient Name: _____ Today's Date: _____

Preferred Name: _____ Pronoun(s): ☐They/Them ☐He/Him ☐She/Her

Birth date: _____ /_____ /_____ SS#:_____-_____-_____ Preferred Language: _____

Address: _____ County _____
City State Zip

Email: _____ No Email ☐ Permission to email: Yes ☐ No ☐

Home #: (_____) _____-_____ Cell #: (_____) _____-_____ Permission to mail: Yes ☐ No ☐

Work #: (_____) _____-_____ Permission to leave messages on phone: Yes ☐ No ☐

Housing-(Check one) Temporary ☐ Stable ☐ Unstable ☐ Best # to leave messages? (Check one) Home ☐ Cell ☐ Work ☐

In case of emergency, notify: _____ Phone #: (_____) _____-_____

Relationship: _____ Discreet: ☐ Yes ☐ No

Orientation: ☐ Hetero ☐ Bi ☐ Gay/Lesbian ☐ Pan ☐ Asexual ☐ _____

Case Manager: _____ # (_____) _____-_____

ASO/CBO: _____

Discreet Calling requested? ☐ Yes ☐ NO

Student Provider: ☐ Yes ☐ NO

Please check all that apply:

☐ White
☐ Asian *(Country of Heritage _____)*
☐ Black/African American/African
☐ Native American/Aleutian/Native Alaskan/Eskimo
☐ Native Hawaiian/Other Pacific Islander
☐ Other: _____

Please check one:
- ❑ Hispanic *(Country of Heritage _____)*
- ❑ Non-Hispanic

Patient HIV/AIDS exposure/risk category (**Please check all that apply**):

☐ Male who has sex with males
☐ Injection drug use
☐ Heterosexual contact
☐ Hemophilia/Coagulation Disorder
☐ Transfusion of blood, blood components, or tissue
- ☐ Perinatal Transmission
- ☐ Other (Please explain): _____

Sexually Active: Yes _____ No _____ Condoms given? _____

Gender:
- ❑ Female (If female, are you pregnant?)
  - ❑ Yes, # of weeks_____ ☐ No
- ❑ Male
- ❑ Transgender (MTF) (FTM)
- ❑ Non-Binary

Primary Guarantor's Name: _____

Household Size: _____ Marital Status: _____

Annual Household Income: $_____

Percent%:_____ Cap: $_____ SBIRT Code: _____ Risk:

Do you have? ☐ Medicare#_____ ☐ Medicaid # _____ ☐ PHIP #_____ ☐ CICP ☐ ADAP

Do you have private medical insurance? ☐ Yes ☐ No ➤ Insurance Provider_____ ID#_____

Do you have private dental insurance? ☐ Yes Insurance Provider: _____ ☐ No

Primary Physician: _____/Agency _____ Phone: _____

ID Physician: _____/Agency _____ Phone: _____

Mental Health Provider (*optional*): _____ Phone: _____

Date of last HIV Blood Draw: _____ CD4 count: _____Viral load: _____ Rx Adherent: Yes____ No_____

Date of HIV diagnosis: _____ Do you have an AIDS diagnosis? Yes ☐ No ☐ Date: _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND TRUE

_____ _____ _____
Patient or Patient Representative Signature Date

Date Completed: __/__/__ *Completed by (Initials):_____* *Updated 08/24/2020*

Colorado Health Network Medical

Most Recent Labs (Month/Year):

Hepatitis C Test: _____ HIV Test: _____ STI(s) Test: _____

Have you ever tested positive for: (if interested in CHN Medical Clinic)

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

If yes to Hepatitis C, have you ever been treated?
Yes _____ No _____

If Yes, what medication? _____

How long was your treatment? _____

Were you able to complete your treatment? Yes _____ No _____

Current Medication: *(Please List ALL Current Medication and Start Date)*

Medication	Start Date	Medication	Start Date	Medication	Start Date
Medication	Start Date	Medication	Start Date	Medication	Start Date
Medication	Start Date	Medication	Start Date	Medication	Start Date

Other Medical:

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**
Would you be interested in a counselling referral? **Yes | No**
What would you like to work on? _____

Social Services:

Would you like to sign-up for the patient portal today? **Yes | No**
Would you like to sign-up for medication reminders? **Yes | No**
Would you like a referral to case management? **Yes | No**
Do you need rental assistance? **Yes | No**
Do you need assistance obtaining housing? **Yes | No**
Do you need assistance obtaining medical insurance? **Yes | No**
Do you need assistance with phone/utility bills? **Yes | No**
Do you need food assistance? **Yes | No**
Do you need transportation assistance? **Yes | No**

Additional Needs/Social Services:

_____
_____
_____
_____
_____
_____

Colorado Health Network Medical

***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? _____

Total: _____

***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: _____

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

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)
- ☐Methylphenidate (Ritalin)
- ☐Alprazolam (Xanax)
- ☐Clonazepam (Klonopin)
- ☐Tramadol
- ☐Diazepam (Valium)
- ☐Zolpidem (Ambien)
- ☐Lorazepam (Ativan)
- ☐Hydrocodone (Vicodin)
- ☐Morphine
- ☐Oxymorphone
- ☐Buprenorphine (Suboxone)
- ☐Methadone
- ☐Carisoprodol (SOMA)
- ☐Psilocybin (Magic Mushrooms)
- ☐Other: _____

Do you have any physical or mental impairment that limits normal activities, including seeing, hearing, walking, or speaking? Do you have any questions or concerns you would like your medical/dental provider to be aware of prior to your first appointment?

_____

_____

_____

Do you have any questions or concerns that you want your provider to know about prior to your visit/appointment?

_____

_____

_____