Common Intake Form

Revised (08/02/2006)

To be completed by the agency:
Agency Based Client I.D. Number: ----------

Intake Date	Last Name	First Name	MI
___/___/_____			

Mother's Maiden Name	Date of Birth	Gender	Social Security Number	At Current Residence Since
	___/___/_____			

Current Address

Street	City	State	Zip	County

Mailing Address

Street	City	State	Zip	County

May we contact the client by mail?	If so, should the mail be confidential?	May we contact the client by phone?	If so, should the call be confidential?	Should messages be confidential?
[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No

Home Phone:	Phone2: Mobile [ ] Work [ ] Other [ ]	E-mail Address

Emergency Contact Information

Emergency Contact Name		Emergency Contact Number		
Street	City	State	Zip	County

Ethnicity: Hispanic / Latino(a)	National Origin of Ethnicity
[ ] Yes [ ] No	

Race: *Check all that apply*
[ ] White [ ] African American [ ] Asian
[ ] Native Hawiian or Pacific Islander
[ ] Native American or Alaskan Native
[ ] Multi-racial [ ] Other

Marital Status	Sexual Orientation	Primary Language

Education level	Veteran?	Do you have special needs?
	[ ] Yes [ ] No	

Client has been in current Living situation since?	Do you receive Housing Assistance?	If yes, from who?
___/___/_____	[ ] Yes [ ] No	_____

If they rent or own, do they have a signed lease/ title/ tax receipt? [ ] Yes [ ] No

Living Situation in last 12 months: *Check all that apply*

[ ] Homeless from the streets	[ ] Jail / Prison
[ ] Homeless from emergency shelter	[ ] Rental housing
[ ] Substance abuse treatment facility	[ ] Rented Room
[ ] Hospital or other medical facility	[ ] Transitional housing
[ ] Domestic violence situation	[ ] Psychiatric facility
[ ] Living with relatives / friends	[ ] Boarding
[ ] Participant - owned housing	[ ] Other

HOPWA

Enrollment Date	Monthly Gross Income	Number of Bedrooms	Application Type
___/___/_____	$		[ ] Individual [ ] Family

Employed	Does the client receive public assistance?	# of People in Household	# of Children in Household
[ ] Full Time [ ] Part Time [ ] Unemployed [ ] Medically Unable [ ] Other	[ ] Yes [ ] No		

Income: Please enter the amount you receive on a monthly basis for the following

Employment / Wages	$	Worker's Compensation	$
SSI	$	TANF	$
SSDI	$	Veteran's Benefits	$
SS Retirement	$	Alimony / Child Support	$
Unemployment Insurance	$	Retirements	$
Long Term Disability	$	Other	$

# of HIV+ people in the household	Household Income $_____	Family Income $_____	# of People in Family

Medical Coverage (Medicaid, Medicare, Private Insurance, etc…)		Medical Coverage (Medicaid, Medicare, Private Insurance, Northstar, etc…)	
Name	Number	Name	Number

Where do you receive your Primary Medical Care?	Where do you receive your Primary HIV Care?
[ ] Alternate/Complimentary Care	[ ] Alternate/Complimentary Care
[ ] County Hospital and DPH Clinics	[ ] County Hospital and DPH Clinics
[ ] Community Based Clinic: Public	[ ] Community Based Clinic: Public
[ ] Community Based Clinic: Private	[ ] Community Based Clinic: Private
[ ] HMO Hospital/Clinics	[ ] HMO Hospital/Clinics
[ ] VA Hospital	[ ] VA Hospital
[ ] Private M.D.	[ ] Private M.D.
[ ] Emergency Room	[ ] Emergency Room
[ ] Other	[ ] Other
[ ] No Primary Care	[ ] No Primary Care

HIV Status

[ ] HIV Negative	[ ] HIV Positive, disease stage unknown
[ ] HIV Positive, asymptomatic	[ ] HIV Positive, symptomatic, not AIDS
[ ] HIV Positive, disabling	[ ] CDC - Defined AIDS
[ ] Disabling AIDS	[ ] Pediatric indeterminate
[ ] Unreported	[ ] Unknown

First year of HIV+	AIDS Diag. Date	County	State	Source

CD4 Date	T-Cell Count	Percent %	Viral Load Date	Relation Value

	STI / Hepatitis	Test Date	Diagnosis	Lab Value	Treatment
[ ]	Genital Herpes				[ ] Yes [ ] No
[ ]	Gonorrhea				[ ] Yes [ ] No
[ ]	Human Papilloma				[ ] Yes [ ] No
[ ]	Syphilis				[ ] Yes [ ] No
[ ]	Chlamydia				[ ] Yes [ ] No
[ ]	Hepatits A				[ ] Yes [ ] No
[ ]	Hepatits B				[ ] Yes [ ] No
[ ]	Hepatits C				[ ] Yes [ ] No

Tuberculosis

Date of PPD/TST	Date PPD / TST Read	X-ray Date	TB Diagnosis	
			[ ]	None
In Treatment	PPD / TST Result	X-ray Result	[ ]	Active
[ ] Yes [ ] No	Reactive	Positive	[ ]	Inactive
TB Treatment Status	Non-Reactive	Negative	[ ]	History of Positive
[ ] N/A	[ ]	Prophylaxis	Multi-Drug Resistance	
[ ] In Treatment	[ ]	None	[ ] Yes [ ] No	

Tuberculosis

Immunizations							
	[ ]	Hepatitis A	[ ]	Hepatitis B	[ ]	Pneumovax
[ ]	Tetanus	[ ]	BCG	[ ]	Influenza	[ ]	PCP

HIV Risk Factors: What behaviors did the individual engage in prior to their first HIV+ test result? *Check all that apply*

- [ ] Sex with a male
- [ ] Sex with a female
- [ ] Injected non-prescription drugs
- [ ] Received clotting factor for coagulation disorder
- [ ] Received transfusion of blood/blood components, organ transplant, Artificial Insemination
- [ ] Worked in healthcare or clinical lab setting
- [ ] Mother HIV infected/ Perinatal transmission
- [ ] Sexual Abuse (Pediatric Only)
- [ ] Other

Sex Partner Risk Factors

- [ ] Intrevenous/injection drug user
- [ ] Bisexual male
- [ ] Person with AIDS or Documented HIV
- [ ] Other

Does Client have a history of Substance Abuse?			Age first used: _____	Frequency	
	[ ] No				
	[ ] Yes	Active in the last 3 months			[ ] Daily
	[ ] Yes	Not active in the last 3 months			[ ] Weekly
					[ ] Monthly

Substance Abuse Treatment Status

				Treatment Start Date
[ ]	In treatment	[ ]	Waiting list for treatment	
[ ]	Refused treatment	[ ]	Completed treatment	
[ ]	Pre-treatment Process	[ ]	Dropped out of treatment	Treatment End Date
[ ]	No active treatment or counseling	[ ]	Other	

Does Client have a history of Mental illness?		
	[ ] No	
	[ ] Yes	Active history in the last 3 months
	[ ] Yes	No active history in the last 3 months

Mental Health Treatment Status

- [ ] In treatment
- [ ] Waiting list for treatment
- [ ] Refused treatment
- [ ] Completed treatment
- [ ] Pre-treatment Process
- [ ] Dropped out of treatment
- [ ] No active treatment or counseling
- [ ] Other

This information is confidential and will be treated accordingly. Statistical data will be reported to Local, State, and Federal Health Departments. I certify that all information in this document is correct and accurate to the best of my knowledge.

Agency

Agency Represenative Signature

Signature

Date