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

Psychosocial Screening

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

Required Form

Client name ______________________ Client # ____________ CM initial ______ Date ___/___/______

☐ Initial screening ☐ Annual 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 ______________________

*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 ______________________

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

Not at all									*Extremely*
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

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

Not at all									*Extremely*
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

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

Domestic safety

Oregon has a law that requires us to report child/elder abuse/neglect. This is called mandatory reporting. If you are under 18 or over 65 years of age, based on your response to the next 3 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/additiction 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						☐	☐	☐
Nicotine (cigs/chew)						☐	☐	☐
Alcohol						☐	☐	☐
Marijuana						☐	☐	☐
Medical marijuana with card						☐	☐	☐
Speed/meth						☐	☐	☐
Cocaine						☐	☐	☐
Hallucinogens						☐	☐	☐
Rx medications						☐	☐	☐

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*
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

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)*

Never									*Always*
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 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 number)*

Not likely									*Very likely*
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 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

Signature and Credentials ____________________ **DATE** ___/___/___