**Psychosocial Screening**

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

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client name: |  | | Client #: |  | | CM initial: | | |  | Date: | /    / |
| Initial screening  Rescreening | | | |  | Date of initial screening: | | | | | | /    / |
| Type of insurance: | |  | | Medical provider: | | |  | | | | |
| From intake: Income? $ | |  | | Social Security number: | | | |  | | | |

### Prior to screening, ensure client has been informed of: purpose of screening, ability to take breaks, ability to skip questions that cause discomfort, mandatory reporting laws and confidentiality.

Living arrangement

Tell me about your current living situation.

|  |  |  |
| --- | --- | --- |
| Permanently housed *(describe)*: | |  |
| Temporarily housed *(describe)*: | |  |
| Unstable *(describe)*: | | |
| **Comments:** | |
| **Plan:** | |

Basic needs *(check if needed)*

Tell me about your basic needs.

Food:

Within the past 12 months:

Were you worried whether your food would run out before you got money to buy more?

Often  Sometimes  Never

The food you bought just didn’t last and you didn’t have money to get more?

Often  Sometimes  Never

Are you receiving SNAP benefits?

No  Yes

If “No”, qualifies for SNAP?

No  Yes  Unsure

|  |  |  |
| --- | --- | --- |
| Clothing  Utilities  Transportation *(non-medical)*  Child care  Personal items *(cleaning, pet supplies etc...)*  Other basic needs:   |  | | --- | | **Comments:** | | **Plan:** | |

Budget

|  |
| --- |
| How are you doing with meeting your monthly expenses? |

| **Income** *(from intake)* | **Monthly Amount** | **Expenses** | **Monthly Amount** |
| --- | --- | --- | --- |
| Salary |  | Rent/mortgage |  |
| Spouse’s salary |  | Phone |  |
| Disability *(short or long-term)* |  | Utilities |  |
| SSI/SSDI  Do you have a payee/conservator? | Yes  No | Food |  |
| TANF/General Assistance |  | Non-food household expenses |  |
| VA pension/retirement |  | Car payment |  |
| Unemployment benefits |  | Insurance premiums |  |
| Child support |  | Alimony/child support |  |
| Savings/investments |  | Child care |  |
| Rental income |  | Uncovered medical expenses |  |
| Family support |  | Debts |  |
| Food benefits (SNAP) |  | Other: |  |
| Other: |  | Other: |  |
| Monthly total | $0.00 | Monthly total | $0.00 |

Transportation

How do you get to your health care appointments?

Public transportation  Ride from family/friend/volunteer

Walk/bike  Medicaid transport

Own vehicle  Taxi/ride service

Other

What barriers, if any, do you face in getting to appointments?

|  |
| --- |
| **Comments:** |
| **Plan:** |

Education

What is the highest grade you completed in school?

No school

K – 8 only

High school/GED Completed?  Yes  No If no, highest grade?

College Completed?  Yes  No

Post-graduate

|  |  |  |
| --- | --- | --- |
| Currently in school?  Yes  No If yes, name: |  | |
| When you have to learn something new, how do you prefer to learn the information?  Listening to an explanation  Talking with people  Trying it for yourself  Watching TV  Reading  Medical terms are complicated, and many people find the words difficult to understand. Do you ever get help from others in filling out forms, reading prescription labels, insurance forms, and/or health education information? | |
| |  | | --- | | **Comments:** | | **Plan:** | | | | |

Employment

Studies show that people who are employed, volunteering or engaged in their community feel better and do better at   
managing their HIV.

|  |  |
| --- | --- |
| Retired  Full-time  Part-time  Temporary/seasonal  Volunteer/intern  Occupation:       How satisfied are you with your current employment? | |
| Unemployed How long have you been unemployed? |  |

How interested are you in gaining employment?

|  |  |
| --- | --- |
| ***Not interested*** | ***Very interested*** |
| 0  1  2  3  4  5  6  7  8  9  10 | |

Can you do the kinds of work you’ve done previously?  Yes  No

|  |  |  |
| --- | --- | --- |
| If yes, what kinds of work? |  | |
| If not, what kinds of work are you interested in? | |  |

What is keeping you from employment?

|  |  |
| --- | --- |
| **Barriers** *(check all that apply)***:** | **Details:** |
| Health related issues |  |
| Fear of losing benefits |  |
| Criminal history |  |
| Applying for jobs |  |
| Transportation |  |
| Childcare |  |
| Education/experience |  |
| Other: |  |

| **Referred to:** | |
| --- | --- |
| Oregon Vocational Rehabilitation Services  WorkSource/One Stop  Supported Employment  Centers for Independent Living | Ticket to Work – if client has SSI/SSDI  Work Incentives Network (WIN) – if client has SSI/SSDI  Vital Purpose (HIV Alliance only)  Other: |

|  |
| --- |
| **Comments:** |
| **Plan:** |

Social support

What are your main support systems?

Spouse/partner  Friends, local  Family, local  Clubs  Support groups

Children  Friends, distant  Family, distant  Pets  Church

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Other: |  | | | | |
| Current spouse or partner: | |  | | | Is partner aware of your HIV status?  Yes  No |
| How do you manage stress? | | |  | | |
| What things do you feel passionate about? | | | |  | |

|  |
| --- |
| **Comments:** |
| **Plan:** |

Mental health history

I am a mandated reporter, if you report to me any immediate threat of harm to yourself or others, I would have to report that. Having thoughts is one thing but having a plan or means to carry it out is another. If you choose not to answer a question, just let me know that you would rather not answer.

|  |
| --- |
| 1. Are you currently diagnosed with a mental health condition?  Yes  No   If yes, what is your mental health diagnosis?  Name of prescribing provider:  1.a. Are you in mental health counseling or therapy for this diagnosis?  Yes  No  If yes, name of agency/provider:  1.b. Do you take medication(s) for this diagnosis?  Yes  No  If yes, name of medication: |
|
|
| 1. Have you been diagnosed with a mental health condition in the past?  Yes  No   If yes, what is your mental health diagnosis?  Name of prescribing provider:  2.a. Are you in mental health counseling or therapy for this diagnosis?  Yes  No  If yes, name of agency/provider:  2.b. Do you take medication(s) for this diagnosis?  Yes  No  If yes, name of medication: |
| 1. Have you ever had an inpatient hospital stay for a mental health condition?  Yes  No   If yes, when, where and reason/diagnosis: |

Mental health screening *(do not need to complete if client is currently in mental health counseling)*

I’d like to ask some questions about your moods or feelings over the past 2-3 months. When asked about how “often” something is experienced, “often” means having feelings or moods 4 days or more in a week.

|  |  |  |
| --- | --- | --- |
| 1. Do you often feel confused? | Yes | No |
| 1. Do you often have trouble concentrating on things, such as reading the newspaper, watching television, or listening to someone give you directions? | Yes | No |
| 1. Do you often have trouble falling or staying asleep, or sleeping too much? | Yes | No |
| 1. Do you often feel anxious, nervous, or worrying a lot about different things? | Yes | No |
| 1. Do you often find yourself feeling sad, down, depressed, or hopeless? | Yes | No |
| 1. Do you find it difficult to enjoy yourself or do you have little interest in doing things you enjoyed in the past? | Yes | No |
| 7. Do you often find yourself reliving bad experiences from the past *(flashbacks, feeling as if you are re-experiencing the event)*? | Yes | No |
| 8. Do you have thoughts of hurting yourself? | Yes | No |
| 9. Do you have thoughts of suicide or ending your life?  If yes, ask: Do you have a plan? Do you have the means to carry-out your plan *(access to weapon, etc.)*? Implement agency suicide plan. | Yes | No |
| 10. Would you like to be referred to a mental health counselor or therapist for any reason? | Yes | No |

If the client answers “yes” to items 1-3, discuss coping mechanisms, consider case conference with MCM, or referral to a medical or mental health provider if these symptoms worsen or don’t improve.

If the client answers “yes” to items 4-10, offer to make a referral to a medical or mental health provider for a more thorough mental health assessment.

|  |
| --- |
| **Comments:** |
| **Plan:** |

Domestic safety

Because violence is common, the next questions have to do with your safety. I want to make sure you get the support you need to be in safe relationships.

*Oregon law requires us to report abuse/neglect of children under the age of 18 and adults 65 years of age or older. This is called mandatory reporting. Based on your responses to the following questions, as a mandated reported, I am required to report abuse, neglect, and an immediate threat of harm to self or others covered under mandatory reporting laws.*

Is anyone in your life physically or emotionally hurting or threatening you?  Yes  No

|  |  |
| --- | --- |
| Comments: |  |

Do you feel controlled by anyone or feel you are in danger?  Yes  No

|  |  |
| --- | --- |
| Comments: |  |

Have you had unwanted sex in the last 3 months?  Yes  No

|  |  |
| --- | --- |
| Comments: |  |

In the last 3 months, has anyone refused to have safe sex with you when you wanted to?  Yes  No

|  |  |
| --- | --- |
| Comments: |  |

Are you concerned about hurting someone?  Yes  No

|  |  |
| --- | --- |
| Comments: |  |

| **Comments:** |
| --- |
| **Plan:** |
| Mandatory reporting required *(follow agency protocol)*?  Yes  No |

Tobacco use

|  |  |
| --- | --- |
| **Ask:** | Current tobacco use?  Yes  No If yes, type:       How much: |
| **Assess:** | On a scale of 1 to 10, how concerned are you about your tobacco use?  On a scale of 1 to 10, how ready are you to quit tobacco? |
| **Assist:** | Referral to Quitline  Referral to Nicotine Replacement Therapy  Referral to medical provider  Not ready to quit – follow up date:    /    / |

|  |
| --- |
| **Comments:** |
| **Plan:** |

Screening, Brief Intervention and Referral to Treatment (SBIRT)

All clients are asked questions about use of alcohol and drugs because substances can affect your health as well as medications you take. One drink equals a 12 oz beer, 5 oz wine or one shot of liquor. Recreational drugs include methamphetamines *(speed, crystal)*, marijuana, inhalants *(paint thinner, glues)*, tranqualizers *(Valium)*, barbituates, cocaine, ecstasy, hallucinogens *(LSD, mushrooms)*, or narcotics *(heroin, Rx painkillers)*

Male/Male-identified: How many times in the past year have you had 5 or more drinks in a day?

None  1 or more *(Complete the AUDIT)*

Female/Female-identified: How many times in the past year have you had 4 or more drinks in a day?

None  1 or more *(Complete the AUDIT)*

How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?

None  1 or more *(Complete the DAST)*

|  |
| --- |
| **Comments:** |
| **Plan:** |

| **Alcohol treatment history** | | | |
| --- | --- | --- | --- |
| Have you ever been in **outpatient** treatment for alcohol problem?  If yes: When and where: | Never | Yes, currently | Yes, In the past |
| Have you ever been in **inpatient** treatment for alcohol problem?  If yes: When and where: | Never | Yes, in the past year | Yes, over a year ago |

| **Audit Score:** | **0** | **1** | **2** | **3** | **4** |
| --- | --- | --- | --- | --- | --- |
| 1. How often do you have a drink  containing alcohol? | Never | Monthly or less | 2 – 4  times a month | 2 – 3 times a week | 4 or more  times a week |
| 1. How many drinks containing alcohol do you  have on a typical day when you are drinking? | 0-2 | 3 or 4 | 5 or 6 | 7 – 9 | 10 or more |
| 1. How often do you have six or more drinks  on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or  almost daily |
| 1. How often during the last year have you  found that you were not able to stop  drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or  almost daily |
| 1. How often during the last year have you  failed to do what was normally expected  of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or  almost daily |
| 1. How often during the last year have you  needed a first drink in the morning to get  yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or  almost daily |
| 1. How often during the last year have you had  a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or  almost daily |
| 1. How often during the last year have you  been unable to remember what happened  the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or  almost daily |
| 1. Have you or someone else been injured  because of your drinking? | No |  | Yes, but not in the last year |  | Yes, in the  last year |
| 1. Has a relative, friend, doctor or other  health care worker been concerned about  your drinking or suggested you cut down? | No |  | Yes, but not in the last year |  | Yes, in the  last year |

|  |  |  |  |
| --- | --- | --- | --- |
| **Audit score results** | | | |
| **Women** | **Men** | **Zone** | **Action** |
| 0 – 3 | 0 – 4 | Low Risk | Brief education – Educate client about low-risk consumption and risks of excessive alcohol. |
| 4 – 12 | 5 – 14 | Risky | Brief intervention/brief treatment – Use MI concepts to raise client awareness of use and enhance motivation to change. Clients with numerous or serious consequences from drinking should receive numerous and intensive interventions with follow-up. Recommended change is to cut back to low-risk drinking unless there are medical reasons to abstain *(liver damage, pregnancy, etc.)*. Consider referral. |
| 13 – 19 | 15 – 19 | Harmful |
| 20+ | 20+ | Dependent | Referral to specialized treatment – Proactive process that facilitates access to specialized care. Client should be referred to alcohol treatment for further assessment. Recommended change is to abstain from use and accept referral. |

| **Substance use** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **N** = Never  **C** = Current  **P** = Past | **Amount** | **Frequency**  Daily, weekly or monthly | **Duration**  <1 year,  1-2 years or >2 years | **Last use**  <1 month,  1-6 months,  6 months-2 years  or >2years | **Use a problem for client?**  X = yes | **Use a problem**  **for others?**  X = yes | **Client wants treatment?**  X = yes |
| Gambling |  |  |  |  |  |  |  |  |
| Cocaine |  |  |  |  |  |  |  |  |
| Hallucinogens |  |  |  |  |  |  |  |  |
| Inhalants |  |  |  |  |  |  |  |  |
| Marijuana |  |  |  |  |  |  |  |  |
| Methamphetamines |  |  |  |  |  |  |  |  |
| Opioids |  |  |  |  |  |  |  |  |
| Rx medication |  |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |  |

| **Substance use/addiction history** | | | |
| --- | --- | --- | --- |
| Do you currently take **more** prescription medication than is prescribed? | Never | Yes, in the past 90 days | Yes, more than 90 days ago |
| Do you currently take prescription medication that is not prescribed to you? | Never | Yes, in the past 90 days | Yes, more than 90 days ago |
| Have you ever injected drugs? | Never | Yes, in the past 90 days | Yes, more than 90 days ago |
| Have you ever been in outpatient treatment for substance addiction?  If yes: When and where:  What substance where you treated for? | Never | Yes, in the past year | Yes, over a year ago |
| Have you ever been in inpatient treatment for substance addiction?  If yes: When and where:  What substance where you treated for? | Never | Yes, in the past year | Yes, over a year ago |

| **DAST Score:** | **0** | **1** |
| --- | --- | --- |
| 1. Have you used drugs other than those required for medical reasons? | No | Yes |
| 1. Do you abuse more than one drug at a time? | No | Yes |
| 1. Are you unable to stop drugs when you want to? | No | Yes |
| 1. Have you ever had blackouts or flashbacks as a result of drug use? | No | Yes |
| 1. Do you ever feel bad or guilty about your drug use? | No | Yes |
| 1. Does your spouse/friend/loved one ever complain about your involvement with drugs? | No | Yes |
| 1. Have you neglected your family because of your use of drugs? | No | Yes |
| 1. Have you engaged in illegal activities in order to obtain drugs? | No | Yes |
| 1. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | No | Yes |
| 1. Have you had medical problems as a result of our drug use (e.g. memory loss, overdose, convulsions, bleeding)? | No | Yes |

| **DAST Score Results** | **Zone** | **Action** |
| --- | --- | --- |
| 0 | Healthy | None |
| 1 – 2 plus:  No daily use of any substance  No weekly use of opioids, cocaine, or methamphetamine  No injection drug use in the past 3 months  Not currently in drug abuse treatment | Risky | Offer advice on benefits and importance of drug abstinence  Monitor and reassess at next visit  Consider providing educational materials |
| 1 – 2 | Risky | Brief intervention/treatment*–*Use MI concepts to raise client awareness of use and enhance motivation to change. Clients with numerous or serious consequences from drug use should receive numerous and intensive interventions with follow-up. Recommended change is to abstain from illicit drug use. Consider referral. |
| 3 – 5 | Harmful |
| 6+ | Dependent | Referral to specialized treatment*–*Proactive process that facilitates access to specialized care. Client should be referred to drug treatment for further assessment. Recommended change is to abstain from use and accept referral. |

Risk assessment

Can you tell me which fluids transmits HIV?

What things are you currently doing to reduce HIV/STD transmission for yourself and others? *Check all that apply.*

|  |  |
| --- | --- |
| Abstinence  Monogamy  Condoms  Disclosure  Adherent to medications  Fewer/no casual or anonymous partners | Sero-matching  Positioning *(receptive vs insertive)*  Partner is on pre-exposure prophylaxis (PrEP)  Not using substances  Clean works  Others: |

Do you think you are doing anything to increase your risk of HIV/STI transmission to yourself or others?

Are there other strategies you could consider to further reduce HIV/STI transmission to yourself and others?

How likely is it that you will use these other strategies? *(Check one)*

|  |  |
| --- | --- |
| ***Never*** | ***Always*** |
| 0  1  2  3  4  5  6  7  8  9  10 | |

***Supplemental Risk assessment***

Are your sex partners:  Opposite sex  Same sex  Both sexes  Non binary  N/A

How many sex partners have you had in the past 12 months:  0  1  2-3  4-10  10+

Do you have:  Vaginal sex  Oral sex  Anal sex  N/A

Have you ever injected drugs with needles?  Yes  No  Medical reasons only

* 1. Do you currently inject drugs with needles?  Yes  No  Medical reasons only
  2. Have you ever shared needles?  Yes  No
  3. Do you currently share needles?  Yes  No

If at any time you decide that you want to notify past or present sex or drug use partners that they may have been exposed to HIV and should get tested, I can help you with that. There are people who can notify them without revealing your identity.

Is this something you might be interested in doing?  Yes  No

***Summary:***

What concerns, if any, do you have about your risk/harm reduction plan?

What questions, if any, do you have about risk/harm reduction?

|  |
| --- |
| **Comments:** |
| **Plan:** |

Legal

Now some questions to help us understand what you would want to happen in an event, like a medical emergency, where you were unable to advocate for yourself.

Do you have  Trust

Will

Advanced Directive *(e.g. do not resuscitate)* – if box not checked, offer a copy

Health care power of attorney *(medical matters)*

Durable power of attorney *(medical and financial matters)*

Guardian/conservator for self/dependents

|  |  |  |  |
| --- | --- | --- | --- |
| If power of attorney, name: |  | Phone: |  |
| Are you a guardian/fiduciary for anyone?  Yes  No If yes, who: | |  | |
| We also ask about criminal history in-order to help me understand barriers you may have. This information is not used against you in anyway.  Criminal history:  Arrest(s)  Conviction(s)  Restraining order(s)  Parole/probation(s)  Incarceration | | | |

|  |  |
| --- | --- |
| **Describe:** | |
| **Comments:** |
| **Plan:** |

Health related education

|  |
| --- |
| Did client report any of the following problems? *(Check all that apply)* |
| Difficulty integrating medications into daily life so can be taken consistently  Struggles with frustration, fear, fatigue, pain, depression and isolation  Challenges maintaining appropriate exercise for improving strength, flexibility and endurance  Problems communicating effectively with family, friends and health professionals  Disclosure issues  Nutrition concerns  Difficulties evaluating symptoms  Questions regarding advanced directives  Ability to understand new or alternative treatments |

Has the client participated in a Health Education, Living Well class, or support group since the last Psychosocial Screening?

Yes  No If yes, list in the comments below.

Is the client interested in receiving Health Education, Living Well class, or support group information now or in the future *(if not currently offered)*?  Yes  No

|  |
| --- |
| **Comments:** |
| **Plan: Referral?**  Yes  No |

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff name and credentials:** |  | **Date:** | /    / |