PUBLIC HEALTH DIVISION
HIV Community Services Program

Oregon Health Authority

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	☐ Ticket to Work – if client has SSI/SSDI
☐ WorkSource/One Stop	☐ Work Incentives Network (WIN) – if client has SSI/SSDI
☐ Supported Employment	☐ Vital Purpose (HIV Alliance only)
☐ Centers for Independent Living	☐ 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:

2. 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:

3. 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
2. Do you often have trouble concentrating on things, such as reading the newspaper, watching television, or listening to someone give you directions?	☐ Yes	☐ No
3. Do you often have trouble falling or staying asleep, or sleeping too much?	☐ Yes	☐ No
4. Do you often feel anxious, nervous, or worrying a lot about different things?	☐ Yes	☐ No
5. Do you often find yourself feeling sad, down, depressed, or hopeless?	☐ Yes	☐ No

6. 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
2. 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
3. How often do you have six or more drinks on one occasion?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
4. 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

Audit Score:	0	1	2	3	4
5. 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
6. 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
7. 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
8. 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
9. Have you or someone else been injured because of your drinking?	☐ No		☐ Yes, but not in the last year		☐ Yes, in the last year
10. 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						☐	☐	☐

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
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
2. Do you abuse more than one drug at a time?		☐ No	☐ Yes
3. Are you unable to stop drugs when you want to?		☐ No	☐ Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?		☐ No	☐ Yes
5. Do you ever feel bad or guilty about your drug use?		☐ No	☐ Yes
6. Does your spouse/friend/loved one ever complain about your involvement with drugs?		☐ No	☐ Yes
7. Have you neglected your family because of your use of drugs?		☐ No	☐ Yes
8. Have you engaged in illegal activities in order to obtain drugs?		☐ No	☐ Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		☐ No	☐ Yes
10. 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	

DAST Score Results	Zone	Action
3 – 5	Harmful	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.
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

a. Do you currently inject drugs with needles? ☐ Yes ☐ No ☐ Medical reasons only
b. Have you ever shared needles? ☐ Yes ☐ No
c. 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:

Client name: _____ Client#: _____ CM initial: _____ Date: ___/___/_____

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:** / /