

## CLIENT ASSESSMENT QUESTIONNAIRE

**INSTRUCTIONS:** Please answer the following questions. Mark  or write a number in the boxes for each question. There are no right or wrong answers. All of your answers are completely confidential and will not be shared with anyone. If you need assistance please ask the person who gave you this form.

- 1) What is your sex / gender? (mark one )
  - (1) Male
  - (2) Female
  - (3) Transgender (male to female)
  - (4) Transgender (female to male)
  - (5) Other identity, specify: \_\_\_\_\_
  
- 2) What is your race / ethnicity? (mark all that apply )
  - (1) Black / African American
  - (1) American Indian / Alaska Native
  - (1) Asian
  - (1) Native Hawaiian / Pacific Islander
  - (1) Hispanic / Latino(a)
  - (1) White
  - (1) Other race, specify: \_\_\_\_\_
  
- 3) What is your birthday / birth date?
 

Month		Day		Year					
  
- 4) What is the FIRST LETTER of your LAST NAME?
  
- 5) What ZIP code do you live in?
  
- 6) What County do you live in? \_\_\_\_\_
  
- 7) Which of the following comes closest to your sexual orientation? (mark one )
  - (1) Heterosexual or straight
  - (2) Bisexual
  - (3) Gay, lesbian, queer, same gender loving, or homosexual
  - (4) Other orientation, specify: \_\_\_\_\_
  
- 8) Have you had sex with a **woman** in the last year (12 months)? (mark all that apply )
  - (1) Vaginal sex (penis in vagina)
  - (1) Anal sex (penis in anus (butt))
  - (1) Oral sex (mouth on penis, vagina, or anus)
  - (1) I have not had sex with a woman in the last year.
  
- 9) Have you had sex with a **man** in the last year (12 months)? (mark all that apply )
  - (1) Vaginal sex (penis in vagina)
  - (1) Anal sex (penis in anus (butt))
  - (1) Oral sex (mouth on penis, vagina, or anus)
  - (1) I have not had sex with a man in the last year.

- 10) Have you had sex in the last year with a sex worker or prostitute (whether you paid or not)?  (1) Yes  (0) No

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  - 11) Have you had sex in the last year with someone that you know injects drugs?  (1) Yes  (0) No

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  - 12) Have you had sex in the last year with someone that you know has HIV or AIDS?  (1) Yes  (0) No

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  - 13) If you are **female**, in the last year have you had sex with a man that you know has had sex with another man?  (1) Yes  (0) No

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  - 14) Have you used a needle to inject drugs in the last year?  (1) Yes  (0) No

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  - 15) Have you used meth, speed, crank, crystal, cocaine, or crack in the last year?  (1) Yes  (0) No

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  - 16) Have you received drugs, money, or other items or services for sex in the last year?  (1) Yes  (0) No

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  - 17) Has a medical or service provider told you that you have gonorrhea or syphilis in the last year?  (1) Yes  (0) No

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  - 18) Has a medical or service provider ever told you that you have hepatitis C?  (1) Yes  (0) No

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  - 19) Have you ever used a needle to inject drugs?  (1) Yes  (0) No

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  - 20) How many HIV/AIDS tests have you had before today?   (enter zero if you never tested before today)
- If you have tested before, what is the date of your last test?
- |       |  |      |  |  |  |  |  |
|-------|--|------|--|--|--|--|--|
|       |  |      |  |  |  |  |  |
| Month |  | Year |  |  |  |  |  |
- If you have tested before, what was the last test result you received? (mark one )
- (1) Negative (No HIV infection)
  - (2) Positive (HIV infection found)
  - (6) Other result, specify: \_\_\_\_\_
  - (5) I have never received a result

**Thank you! Please return this completed form now.**

## CLINIC USE ONLY

<b>ADMINISTRATIVE</b>	Data entry initials: <input style="width: 40px; height: 20px;" type="text"/>	Agency ID: <input style="width: 40px; height: 20px;" type="text"/>	(date and initial)	Date (mm/dd/yy)	Initials (print)	
	<input type="checkbox"/> (1) Mark <input checked="" type="checkbox"/> if no billing	Intervention: _____	Intervention session: <input style="width: 40px; height: 20px;" type="text"/>	Disclosure session: (same date as intervention for rapid tests)	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>
<b>CLIENT ASSESSMENT</b>	Assessment initials: <input style="width: 40px; height: 20px;" type="text"/>	Intervention ID: <input style="width: 40px; height: 20px;" type="text"/>	Reschedule attempt: (for missed HIV confidential disclosures)	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	
	Initial intervention:	Location ID: <input style="width: 40px; height: 20px;" type="text"/>	Reschedule attempt outcome: (mark one <input checked="" type="checkbox"/> if no HIV disclosure)	<input type="checkbox"/> (1) Unable to locate/contact	<input type="checkbox"/> (3) Obtained HIV results elsewhere	
	<input type="checkbox"/> (1) LR low-level (indicate transition) <input type="checkbox"/> LR high-level (CIF required) <input type="checkbox"/> HR high-level (CIF required)	HIV test election: (mark one <input checked="" type="checkbox"/> )	<input type="checkbox"/> (2) Client declined notification	<input type="checkbox"/> (4) Rescheduled but client did not return		
	Transition to high-level? <input type="checkbox"/> Yes (CIF required) <input type="checkbox"/> (0) No	<input type="checkbox"/> (1) Tested anonymously <input type="checkbox"/> (2) Tested confidentially <input type="checkbox"/> (3) Client declined testing <input type="checkbox"/> (4) HIV test not offered	<b>Note:</b> CIF is required for all preliminary positive rapid tests.			
Local variance used? <input type="checkbox"/> Yes (CIF required) <input type="checkbox"/> (0) No						

<b>OTHER TESTING</b>	Referred for hepatitis C testing? (mark one <input checked="" type="checkbox"/> ) <input type="checkbox"/> Yes (CIF required) <input type="checkbox"/> No	<b>HIV TEST SUMMARY</b>	Final HIV test result: (mark one <input checked="" type="checkbox"/> ) (attach lab slips/ Testing Incident Report)	<b>OPTIONAL DATA</b>	Item 1:
	Additional tests this visit: (mark all that apply <input checked="" type="checkbox"/> ) <input type="checkbox"/> (1) No additional tests <input type="checkbox"/> (1) Tuberculosis (TB) <input type="checkbox"/> (1) Hepatitis B <input type="checkbox"/> (1) Syphilis <input type="checkbox"/> (1) Gonorrhea <input type="checkbox"/> (1) Chlamydia <input type="checkbox"/> (1) Other STD (other than HIV)		<input type="checkbox"/> (1) Negative <input type="checkbox"/> Positive (CIF required) <input type="checkbox"/> Preliminary positive (CIF required) (no confirmatory sample taken) <input type="checkbox"/> Inconclusive (CIF required) <input type="checkbox"/> Discordant (CIF required) <input type="checkbox"/> (6) Invalid <input type="checkbox"/> Other result, specify (CIF required)		Item 2:
			Item 3:		
			Item 4:		

<b>NOTES</b>	

HR = High-Risk Client    LR = Low-Risk Client    CIF = HIV Counseling Information Form    STD = Sexually Transmitted Disease or Infection

Place additional lab stickers here:	<b>LAB SLIP #2</b>	<b>LAB SLIP #3</b>	<b>LAB SLIP #4</b>	<b>LAB SLIP #5</b>
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