

CLIENT ASSESSMENT QUESTIONNAIRE

Unique Office of AIDS
Client Number

INSTRUCTIONS: Please answer the following questions. Mark one response for each question unless instructed otherwise. 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 gender identity?
 - (1) Male
 - (2) Female
 - (3) Transgender (male to female)
 - (4) Transgender (female to male)
 - (5) Other identity, specify: _____

- 2) What was your biological gender at birth?
 - (1) Male
 - (2) Female
 - (3) Intersex

- 3) 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: _____
 - (1) I prefer not to answer.

- 4) What is your date of birth?

		/			/				
Month			Day			Year			

- 5) What is the FIRST LETTER of your LAST NAME?

- 6) What ZIP code do you live in?

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- 7) What county do you live in? _____

- 8) Are you currently homeless? (1) Yes (0) No

- 9) Which of the following comes closest to your sexual orientation?
 - (1) Heterosexual / straight
 - (2) Bisexual
 - (3) Gay, lesbian, queer, or same gender loving
 - (4) Other orientation, specify: _____
 - (5) I do not know my sexual orientation.

- 10) What is your current health insurance coverage? *(mark all that apply)*
 - (1) No health insurance coverage
 - (1) Private *(Kaiser, Sutter, Blue Cross, HMO, etc.)*
 - (1) Medi-Cal (Medicaid)
 - (1) Medicare
 - (1) Military *(active duty, veteran, or family member)*
 - (1) Indian Health Service
 - (1) Other coverage, specify: _____

- 11) Have you been tested for HIV/AIDS before today?
 - (1) Yes
 - (0) No
 - (8) I do not know if I have tested before today.
 - (9) I prefer not to answer.

If yes, what was the last test result you received?

 - (1) Negative *(No HIV infection)*
 - (2) Positive *(HIV infection found)*
 - (3) Preliminary positive *(Positive screening but not confirmed)*
 - (4) Other result *(Inconclusive, discordant, or invalid)*
 - (5) I do not know my last test result.
 - (6) I have never received a test result.
 - (7) I prefer not to answer.

What is the date of the last test result you received?

		/				
Month			Year			

If your last test result was positive, what is your reason for testing today? *(please specify)*

- 12) Have you had sex with a **man** in the past 12 months? (1) Yes (0) No

If yes, what type of sex have you had with **men** in the past 12 months? *(mark all that apply)*

 - (1) Vaginal sex *(penis in vagina)*
 - (1) Anal insertive sex *(your penis in your partner's anus (butt))*
 - (1) Anal receptive sex *(your partner's penis in your anus (butt))*
 - (1) Oral sex

- 13) Have you had sex with a **woman** in the past 12 months? (1) Yes (0) No

If yes, what type of sex have you had with **women** in the past 12 months? *(mark all that apply)*

 - (1) Vaginal sex *(penis in vagina)*
 - (1) Anal sex *(penis in anus (butt))*
 - (1) Oral sex

- 14) Have you had sex with a **transgender** person in the past 12 months? (1) Yes (0) No

If yes, what type of sex have you had with **transgender** persons in the past 12 months? *(mark all that apply)*

 - (1) Vaginal sex *(penis in vagina)*
 - (1) Anal insertive sex *(your penis in your partner's anus (butt))*
 - (1) Anal receptive sex *(your partner's penis in your anus (butt))*
 - (1) Oral sex

Please continue on reverse side

- 15) How many people have you had vaginal or anal sex with in the past 12 months? (1 to 999)
- 16) Have you had vaginal or anal sex without using a condom in the past 12 months? (1) Yes (0) No
- 17) Have you received drugs, money, or other items or services for sex in the past 12 months? (1) Yes (0) No
- 18) Have you had sex with someone that you know has HIV or AIDS in the past 12 months? (1) Yes (0) No
- 19) Have you had sex with someone that you know injects drugs in the past 12 months? (1) Yes (0) No
- 20) If you are **female**, in the past 12 months have you had sex with a man that you know has had sex with another man? (1) Yes (0) No
- 21) Have you used any of these drugs in the past 12 months? (mark all that apply)
- (1) Speed (crystal, meth, tina, amphetamines)
 - (1) Powder cocaine
 - (1) Crack (rock)
 - (1) Poppers (amyl nitrate)
 - (1) I have not used any of these drugs.

- 22) Have you used a needle to inject drugs in the past 12 months? (1) Yes (0) No
- If you have injected, did you share needles or drug injection equipment in the past 12 months? (1) Yes (0) No
- If you have injected, which drugs have you injected in the past 12 months? (mark all that apply)
- (1) Speed (crystal, meth, tina, amphetamines)
 - (1) Powder cocaine
 - (1) Crack (rock)
 - (1) Heroin (dope, junk, skag, smack, H)
 - (1) Other drug, specify: _____
- 23) Have you ever used a needle to inject drugs? (1) Yes (0) No
- 24) Has a medical or service provider ever told you that you have hepatitis C? (1) Yes (0) No
- 25) Have you been diagnosed with any of following in the past 12 months? (mark all that apply)
- (1) Chlamydia
 - (1) Gonorrhea
 - (1) Syphilis
 - (1) I have not been told I have any these.
- 26) Is there anything else that may have put you at risk for HIV?
 (1) Yes (please specify below)
 (0) No
- If yes, then please specify: _____

Thank you! Please return this completed form now.

CLINIC USE ONLY					
ADMINISTRATIVE	Data entry ID: <input type="text"/>	Agency ID: <input type="text"/>	(indicate date and provider ID)		
	CLIENT ASSESSMENT: <input checked="" type="checkbox"/> (1) CAQ was used HIV risk assessment: (optional) <input type="checkbox"/> (1) Low <input type="checkbox"/> (2) High HCV risk assessment: (optional) <input type="checkbox"/> (1) Low <input type="checkbox"/> (2) High	Intervention: _____ Intervention ID: <input type="text"/> Location ID: <input type="text"/> HIV test election: (mark one <input checked="" type="checkbox"/>) <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	Intervention session: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Disclosure session: (same date as intervention for rapid tests) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Confirmatory disclosure: (rapid confirmatory results) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Reschedule attempt: (for missed HIV confidential disclosures) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input 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"/> (2) Client declined notification <input type="checkbox"/> (4) Rescheduled but client did not return HCV result disclosure: (may be same date as HIV disclosure) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date (mm/dd/yy) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Provider ID <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
RISK REDUCTION	Risk reduction counseling provided? (mark one <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Yes, counseling provided <input type="checkbox"/> (2) No, counseling not offered <input type="checkbox"/> (3) No, client declined/refused Risk reduction plan developed? (mark one <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Yes, plan developed <input type="checkbox"/> (2) No, service not offered <input type="checkbox"/> (3) No, client declined/refused	REFERRALS	Referrals: (mark all that apply <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) No referrals provided <input type="checkbox"/> (1) HIV education and prevention services <input type="checkbox"/> (1) Substance use services <input type="checkbox"/> (1) Syringe exchange program <input type="checkbox"/> (1) STD testing <input type="checkbox"/> (1) Hepatitis vaccination, testing, treatment, or services <input type="checkbox"/> (1) Non-HIV medical services <input type="checkbox"/> (1) Other referral, specify: _____	HCV TESTING	Hepatitis C test conducted? (mark one <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Yes, test conducted (indicate result below) <input type="checkbox"/> (2) No, test not offered <input type="checkbox"/> (3) No, client declined HCV test result: (mark one <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Negative <input type="checkbox"/> (2) Positive <input type="checkbox"/> (3) Inconclusive
	RISK REDUCTION		REFERRALS		HCV TESTING
Place additional lab stickers here:		LAB SLIP #2		LAB SLIP #3	