



# PSYCHOSOCIAL SCREENING

Check appropriate box:

Initial Screening     Annual/On-Going Screening

<b>Summary</b>	
(Fill out for CAREWare after assessment completed)	
<p style="text-align: center;"><b>Mental Health History</b></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Yes, active within last 3 months</p> <p><input type="checkbox"/> Yes, but not active within last 3 months</p>	<p style="text-align: center;"><b>Substance Abuse History</b></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Yes, active within last 3 months</p> <p><input type="checkbox"/> Yes, but not active within last 3 months</p>

## I. MENTAL HEALTH SCREENING:

NO CHANGE

If any of the following questions are answered "No" and client reports memory loss, refer client to mental health professional for further 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 client have a mental health history/diagnosis?     Yes     No

Explain: \_\_\_\_\_

Has client ever been hospitalized for a mental health condition?     Yes     No

Date	Where	Reason	Duration

Has client ever or is client currently (within 3 months) on medication for a mental health condition?

Yes     No

Prescribed Medication	Purpose	Dates on Medication

Reasons for discontinuing mental health medication(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client Name \_\_\_\_\_ Client # \_\_\_\_\_ CM Initial \_\_\_\_\_ Date \_\_\_\_\_

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**I. MENTAL HEALTH SCREENING (Continued):**

Are any of the following a problem to the client?

- Depression     Yes     No                      Anxiety     Yes     No                      Suicidal thoughts     Yes     No  
Delusional     Yes     No                      Insomnia     Yes     No                      Forgetfulness             Yes     No  
Dementia       Yes     No                      Withdrawal/Isolations     Yes     No

Is client currently (last 3 months) enrolled in a treatment program?     Yes     No

If yes, please identify:

Clinician	Program	Address	Phone and Fax	Aware of Client's HIV Status? Y/N

**Treatment Options**

- In treatment                       Waiting list for treatment                       Refused treatment  
 Not applicable                       Pre treatment process                       Dropped out of treatment  
 Unknown                       Completed treatment                       No active treatment or counseling  
 Other \_\_\_\_\_

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**(Ask ONLY if written Agency Policy on Suicide is in place)**

Has client had thoughts of hurting self/others?                       Yes     No

Does client have a plan?                       Yes     No

How specific is the plan? \_\_\_\_\_

Does the client have the means?                       Yes     No

If a yes was chosen, describe:

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Client Name \_\_\_\_\_ Client # \_\_\_\_\_ CM Initial \_\_\_\_\_ Date \_\_\_\_\_

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**I. MENTAL HEALTH SCREENING (Continued):**

**(Ask ONLY if written Agency Policy on Suicide is in place)**

Has client ever attempted to hurt self/others?  Yes  No

If yes, describe:

***If the client answered "Yes" to any of the suicide questions, please refer to your agency Suicide Policy for mental health contact information and the appropriate response.***

How troubled has the client been with mental health problems in the past 3 months?

- Not at all
- Slightly
- Considerably
- Moderately
- Extremely

Is client interested in counseling/therapy/support group?  Yes  No

Comments:

**Refer to Mental Health Assessment**  Yes  No

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Client Name \_\_\_\_\_ Client # \_\_\_\_\_ CM Initial \_\_\_\_\_ Date \_\_\_\_\_

**II. SUBSTANCE USE/ADDICTION SCREENING AND HISTORY:**

**NO CHANGE**

- Does client believe drugs/ETOH are a problem?  Yes  No
- Ever had A&D related justice contacts?  Yes  No
- Ever had a DUI?  Yes  No      Ever had a blackout?  Yes  No
- Has client ever used a needle to inject drugs?  Yes  No
- Have any of client's sex partners ever used needles to inject drugs?  Yes  No  I don't know
- Drug/ETOH related ER or hospitalizations?  Yes  No
- Ever been told drugs/ETOH are a problem?  Yes  No

- Ever experience financial difficulty due to gambling?  Yes  No
- Ever been told gambling is a problem?  Yes  No
- Does client believe gambling is a problem?  Yes  No

- Ever been in a treatment program?  Yes  No
- If yes, for what addiction/when? \_\_\_\_\_
- Ever attended a recovery program?  Yes  No
- If yes, for what addiction/when? \_\_\_\_\_

SUBSTANCE USE/ ABUSE/ ADDICTION	IF CURRENT (circle the X)	AMOUNT FREQUENCY (daily/weekly/monthly)	DURATION (<1yr, 1-2yrs, >2yrs)	LAST USE (<1mo,1-6 mos, 6mos-2yrs, >2yrs)
Gambling	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Nicotine	<input type="checkbox"/> Yes <input type="checkbox"/> No	cigs/chew		
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	OZS		
Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Cocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Opiates	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Speed/Meth	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Hallucinogens	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Rx Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No			
IDU	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Share Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No			

- Is client using shared equipment?  Yes  No
- If yes, how much of the time are you able to use clean needles? \_\_\_\_\_
- Is client interested in receiving information about needle exchange or safe needle practices?  Yes  No
- Is client interested in Addiction Counseling?  Yes  No

**Refer to Substance Use/Addiction Assessment**  Yes  No

Client Name \_\_\_\_\_ Client # \_\_\_\_\_ CM Initial \_\_\_\_\_ Date \_\_\_\_\_

**III. RISK ASSESSMENT/HARM REDUCTION:**

**NO CHANGE**

Is client currently in a relationship?  Yes  No If yes, how long? \_\_\_\_\_

Has the client had additional sexual/needle partners in the past year?  Yes  No

Additional information client shares about these partners: \_\_\_\_\_

Number of sexual partners in the past year?  0  1  2-3  4-10  10+  
 Same sex  Other sex  Both sexes  
 Vaginal sex  Anal sex  Both  
 Anonymous encounters

What does the client think they are doing that may be a risk for transmitting HIV to a partner (sexual or needle sharing partners)? \_\_\_\_\_

Have all of the client's sexual/needle sharing partners been informed of their HIV status?  Yes  No

What is the client doing to protect themselves and their partner from infection?

- Condoms  Clean needles and works  Abstinence  One partner
- Oral sex instead of anal sex  Top anal instead of bottom anal
- Other risk reduction Describe: \_\_\_\_\_

If the client states that they are using condoms: In the last 3 months, how often did the client use condoms during sex?  Always  Most times  Sometimes  Never

In the last 3 months, how often did the client's partner use a condom?  Always  Most times  Sometimes  Never  Don't know

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

In the past 12 months, have any of the client's sex partners been told they had a sexually transmitted infection?  Yes  No  Don't know If yes, which ones: \_\_\_\_\_

What additional information has the client requested about their sexual risk? \_\_\_\_\_

What's the one thing the client thinks they can do to reduce the risk to themselves and their partners? \_\_\_\_\_

**Refer to "Supporting Healthy Options For Prevention" (SHOP): 1-877-795-7700.**

Client Name \_\_\_\_\_ Client # \_\_\_\_\_ CM Initial \_\_\_\_\_ Date \_\_\_\_\_

**IV. SOCIAL SUPPORTS:**

NO CHANGE

Current spouse or partner \_\_\_\_\_

Is spouse/partner aware of client's HIV status?  Yes  No

Indicate others who client identifies as supports:

Name	Relationship	Aware of Client's HIV status? Y/N

**Oregon has a law that requires us to report child or elder abuse or neglect. This is called mandatory reporting and is an important protection. If you are under 18 years of age or over 65 years of age, based on your response to the next three questions I may be required to report your situation.**

Has your partner or ex-partner ever hit you or physically hurt you? Have they ever threatened to hurt you or someone close to you?  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your partner ever forced you to have sex when you didn't want to? Has your partner ever refused to practice safe sex?  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Case Manager Signature & Credentials:** \_\_\_\_\_

Client Name \_\_\_\_\_ Client # \_\_\_\_\_ CM Initial \_\_\_\_\_ Date \_\_\_\_\_