



Organization Name:	Program Name:	Date:
Individual's Name (First MI Last):	Record #:	DOB:

(Required For OASAS; as Clinically Indicated for Office of Mental Health Programs)

Sexual Behavioral Assessment

How many sexual partners have you had? None One Two Three More than Three

Have you ever....

	No	Yes
Had sex while high on drugs or alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Had sex to get money, drugs, shelter, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Paid for sex with money and/or drugs	<input type="checkbox"/>	<input type="checkbox"/>
Had sex with an individual who injects drugs	<input type="checkbox"/>	<input type="checkbox"/>
Had unprotected sex	<input type="checkbox"/>	<input type="checkbox"/>
Had unprotected anal and/or vaginal sex with someone:		
Who was HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
Whose HIV status you did not know	<input type="checkbox"/>	<input type="checkbox"/>
Had sex against your will	<input type="checkbox"/>	<input type="checkbox"/>
Do you use condoms and/or other protective devices when engaging in sexual activities?	<input type="checkbox"/>	<input type="checkbox"/>

Needle Use Assessment

If you have injected drugs in the past what kind of needles did you use?

	Yes	No
New	<input type="checkbox"/>	<input type="checkbox"/>
Bleached	<input type="checkbox"/>	<input type="checkbox"/>
Shared (someone used before me)	<input type="checkbox"/>	<input type="checkbox"/>
Shared (someone used after me)	<input type="checkbox"/>	<input type="checkbox"/>
Reused my own	<input type="checkbox"/>	<input type="checkbox"/>
Origin unknown		<input type="checkbox"/>

Testing

Have you ever had a TB test? No Yes

If Yes, what was the date of your last PPD test? Date: _____ Results: Positive Negative Unknown

Results of your last chest x-ray:

Have you ever been tested for Hepatitis A, B or C? No Yes

If Yes, what was the outcome? Positive Negative If Positive, were you referred for medical care? No Yes

Have you ever been given a Hepatitis vaccine (Twin Rx)? No Yes

Have you ever been tested for HIV? No Yes



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If yes, date of last test: _____ - Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown			
Completed By - Print Name:		Signature:	Date:

Part B. Medical Assessment – (To be completed by Medical Staff/Reviewer)

Vital Signs/Physical Health Indicators <i>(Required, Where Indicated, For PROS W/CLINIC & Vitals Required for COA Opioid and Strongly Recommended for Others)</i>			
Blood Pressure:	Abdominal girth:	Temperature:	Pulse:
Respiration:	Height:	Weight:	BMI:
Nutritional/Hydration Status			
If individual answered yes to any of the items in Nutrition/Hydration Screening above, provide referral information below or rationale if no further action taken:			
Does individual have any medical concerns that may interfere with treatment or for which s/he needs assistance? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If Yes, explain:			
Pain Assessment			
Individual has pain based on Pain Screen section above: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, complete:			
Site #1	Site #2		

