# Sexual Health Assessment:

**On a scale of one to five, how would you rank your knowledge of how the following are transmitted and how they are prevented? With one being totally unsure of routes of transmission and how they are prevented and five being knowledgeable.**

* 1. HIV: 1 2 3 4 5
	2. STIs: 1 2 3 4 5
	3. Hepatitis C (HCV): 1 2 3 4 5

**On a scale of one to five, based on what you know about how the following are transmitted and your own behaviors, what do you think your level of risk is? With one being low to no risk and five being extremely high risk.**

1. HIV: 1 2 3 4 5
2. STIs: 1 2 3 4 5
3. HCV: 1 2 3 4 5

**Have you ever heard of PrEP?** [*Pre-exposure prophylaxis (PrEP) is a daily pill taken to prevent HIV*]

* Yes
	+ Have you taken PrEP in the last 12 months?
		- No
		- Yes
			* If yes, are you currently on PrEP?
				+ No
				+ Yes
* No (if applicable, discuss PrEP)
	+ Do you think you might benefit from PrEP?
		- No
		- Yes

**Have you ever heard of PEP?** [*Post-exposure prophylaxis (PEP) is an emergency medication that can stop an HIV infection if started within 72 hours of exposure to HIV and continued for 28 days*]

* No (if applicable, discuss PEP)
* Yes
	+ Have you ever used PEP?
		- No
		- Yes
			* If yes, how many times? \_\_\_\_

**In the past 72 hours, have you had sex without a condom or shared injection equipment with someone who has HIV or whose HIV status you don’t know?**

* No
* Yes

# HIV/STI/HCV Testing History:

**Have you ever been tested for:**

 HIV □ Yes □ No □ Don’t Know If Yes, Date Result:

HCV □ Yes □ No □ Don’t Know If Yes, Date Result:

Gonorrhea □ Yes □ No □ Don’t Know If Yes, Date Result:

Chlamydia □ Yes □ No □ Don’t Know If Yes, Date Result:

Syphilis □ Yes □ No □ Don’t Know If Yes, Date Result:

**In the past 6 months, have you been told by a health care provider that you have gonorrhea, chlamydia, or syphilis?**

* Yes
* No
* Don’t know/not sure
* Chose not to answer

**Are you currently experiencing any symptoms related to a sexually transmitted infection, such as:**

* Discharge?
* Itching/burning?
* Skin changes/rash?
* Fever/sweats?
* Genital or anal lesion (sore, ulcer, abscess, etc.)?
* Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Behavioral Assessment (check all that apply):

**Have you ever:**

* Received a tattoo or body piercing by a non-professional or in an unlicensed setting (jail, etc.)?
* Had an occupational exposure to blood or bodily fluids?
* Received a blood transfusion/organ transplant prior to 1992?
* Had a blood clotting factor concentrate produced prior to 1987?
* Received long term hemodialysis?
* Had household contact with someone living with hepatitis C infection?
* Been sexually active?

**When you had sex, was it:**

* For fun/sexual pleasure?
* To get something, you needed such as money, drugs, food, or housing?
* At a time when you did not want to?
* Always with a condom?

**Tell me a little more about what sex looks like for you. What body parts of yours touched what body parts of partners? For example, did your [select a body part/object from the ‘did your’ list] touch their [select a body part/object from the ‘touch their’ list]?**

|  |  |
| --- | --- |
| Did your:  | Touch their:  |
| * Mouth
 | * Mouth
 |
| * Penis
 | * Penis
 |
| * Anus
 | * Anus
 |
| * Vagina
 | * Vagina
 |
| * Toys
 | * Toys
 |
| * Fingers/Hand
 | * Fingers/Hand
 |

**How many sexual partners have you had:**

* In the last 6 months? \_\_\_\_
* In the last 5 years? \_\_\_\_

**To your knowledge were any of your sexual partners:**

* Someone who received a tattoo or body piercing by a non-professional or in an unlicensed setting (jail, etc.)?
* Someone who used a needle to inject any drugs?
* Someone who used a needle to inject other substances (e.g., silicone, hormones)?
* A man who has sex with other men?
* Someone who engages in sex to get something they needed such as money, drugs, food, or housing?
* Recently diagnosed with an STI (gonorrhea, chlamydia, or syphilis)?
* Living with HCV?
* Living with HIV?
* If yes, did they tell you they had an undetectable viral load at their last medical appointment?
	+ Yes
	+ No
	+ Don’t know
* If yes, what preventive measures did you use? Check all that apply.
	+ - * Condom
			* PrEP
			* PEP
			* Partner has an undetectable viral load
			* Other (Please Specify)
			* None of these
			* Prefer not to answer

**In the past 6 months, have you used any of the following to prevent yourself from becoming infected with HIV, STIs, and HCV?**

* PrEP
* PEP
* Condoms
* Finger cots or other latex/silicon barriers
* Frequent testing for HIV, STIs, and HCV
* Communicating with partners about sexual health
* Used a new needle/drug injection equipment for every shot
* Other prevention options: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In which situations are you or your partner(s) more likely to use condoms?**

**Is there anything else you want to tell me about your sex partners?**

# Substance Use History

**Do you have a history of?**

|  |  |  |  |
| --- | --- | --- | --- |
| Drug use? | □ Yes □ No | Drug abuse? □ Yes □ No | Drug addiction? □ Yes □ No |
| Alcohol use? | □ Yes □ No |  Alcohol abuse? □ Yes □ No |  Alcohol addiction? □ Yes □ No |

**What is your drug(s) of choice?**

**Have you ever used injection drugs?** □ Yes □ No

**If yes, do you share works?** □ Yes □ No

**If yes, do you clean them first?** □ Yes □ No **If yes, how?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you snort drugs?** □ Yes □ No Do you share snorting straws? □ Yes □ No

**Have you ever been in drug and/or alcohol abuse treatment?** □ Yes □ No

**If yes, where and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*A ‘yes’ response to any of the questions above may indicate the need for linkage/referral to substance use services.*

# Mental Health History

**Do you have a history of diagnosed mental health issue?** □ Yes □ No

If yes, what is the official diagnosis/diagnoses provided to you by a professional? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you take medications for mental health issues?** □ Yes □ No

##  If yes, please list:

**Are you currently seeing a mental health provider?**

* Yes
* No
* Can’t recall/don’t know
* Chose not to answer

**Do you have any current or have you had past thoughts of hurting yourself or others?** □ Yes □ No

* If yes, please describe:

### In the past year:

### Was there a time when you felt sad or depressed for more than two weeks in a row? □ Yes □ No

* Did you lose interest in things like hobbies or activities that usually give you pleasure? □ Yes □ No
* Was there a time when you suddenly felt frightened, anxious, or very uneasy? □ Yes □ No

*A ’yes’ response to any of the above questions may indicate the need for linkage/referral to mental health services.*

# Trauma History:

### During your lifetime, as a child or adult, have you experienced or witnessed traumatic event(s) that involved harm to yourself or to others? □ Yes □ No

### If yes, have you been troubled by flashbacks, nightmares, or thoughts of the event(s) in the past year? □ Yes □ No

### Have you talked with your counselor about the event? □ Yes □ No

*A ‘yes’ response to any of the above questions, and not already engaged in care, may indicate the need for linkage/referral to mental health services.*

# Personal Safety / Intimate Partner Violence History

**Are you concerned about your safety at home?**

* Yes
* No
* Chose not to answer

**Has your partner ever:**

* Physically hurt you?
* Insulted you or talked down to you?
* Threatened you with harm?
* Screamed or cursed at you?

*A ‘yes’ response to any of the above may indicate the need for linkage/referral to domestic violence services, a domestic violence shelter and/or the development of a safety plan.*

# Medical Care

**Do you have a doctor or other healthcare provider?**

* Yes
* No
* Can’t recall/don’t know
* Chose not to answer

**When did you last visit a doctor or health care provider?**

* Date: \_\_\_\_\_\_\_\_\_\_
* Date Unknown
	+ If unknown, what is your best estimate of the date of your last visit?
		- Within the last 6 months
		- More than 6 months ago
		- More than 1 year ago

# Insurance Status

**Do you currently have health insurance?**

* Yes
	+ If yes, what type (private, Medicaid, Medicare)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No
* Can’t recall/don’t know
* Chose not to answer

# Housing Status

**What is your current housing status?**

* + Stable housing (rent or own)
	+ Unstable housing (homeless on the street, staying with friends, couch surfing, in a shelter)

**Do you have a history of housing instability?**

* Yes
* No
* Can’t recall/don’t know
* Chose not to answer

# Food Security

**In the past 30 days, did you ever go a day without anything to eat because you did not have adequate access to food?**

* Yes

If yes, are you aware of food pantries/service agencies?

* + - Yes
		- No
* No
* Can’t recall/don’t know
* Chose not to answer

# Legal History

**In the past year, have you experienced formal incarceration (e.g., jail, prison, juvenile detention)?**

* Yes
* No
* Can’t recall/don’t know
* Chose not to answer

# Transportation

**In the past 6 months, have your struggled with or have you been unable to access services such as medical care, substance use treatment, mental health services, food pantries, etc. because you haven’t had transportation?**

* Yes
* No
* Can’t recall/don’t know
* Chose not to answer

# Disposition

Based on the comprehensive behavioral risk assessment screening and discussions with the client:

* Is the client eligible, interested, and ready for HIV Navigation Services (HNS)?
* Yes – enroll the client in HNS and complete an Action Plan
* No – refer to other identified services:
* HIV testing Where/With?
* STI screening Where/With?
* Hepatitis C screening Where/With?
* PrEP Where/With?
* PEP Where/With?
* PrEP support group Where/With?
* Primary Care Where/With?
* Peer Training Where/With?
* Intimate partner violence support group? Where/With?
* Food pantry/services Where/With?
* Legal Services Where/With?
* Other: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where/With?
* Other: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where/With?
* Other: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where/With?
* Additional Assessments for
	+ Substance Use Where/With?
	+ Mental Health Where/With?

**Note:** *If the assessment indicates the need for a referral/linkage to additional service(s) and the client is ready to accept a linkage/referral (regardless of whether they are ready to engage in HNS), the client must be linked/provided additional information as applicable.*

Overall Comments/ Notes:

|  |
| --- |
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|  |
|  |

**Conducted By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***(Staff signature) (Date)***

**Reviewed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***(Supervisor signature) (Date)***