Person's Name (First MI Last):	**Record #:**	**Date of Admission:**
Organization/Program Name:	**DOB:**	**Gender:** ☐ Male ☐ Female ☐ Transgender

(Check all that apply below)

1. What drugs do you usually use? ☐ N/A
☐ Heroin ☐ Other Opiates ☐ Cocaine ☐ Alcohol ☐ Methadone ☐ Benzodiazepines
☐ Inhalants ☐ Marijuana ☐ Amphetamines ☐ Other: _____

2. How do you use your drugs? ☐ N/A
☐ Inject ☐ Oral ☐ Smoke ☐ Snort ☐ Other: _____

3. If you inject drugs, how often do you use new needles? ☐ N/A
☐ Sometimes ☐ Always ☐ Never

4. If you use new needles, where do you get them? ☐ N/A
☐ Pharmacy ☐ Friends ☐ Needle Exchange ☐ Other _____

5. If you use needles, how do you dispose of them? ☐ N/A
☐ Throw Away ☐ Needle Exchange ☐ Bring to Pharmacy ☐ Disposal Site ☐ Other _____

6. Do you ever share needles/injection equipment? ☐ N/A
☐ Yes ☐ No

7. In the last five years, about how many people have you had sex with?
☐ 20 or more ☐ 10-19 ☐ 3-9 ☐ 0-2

8. How often do you use protection against infections? ☐ N/A
☐ Sometimes ☐ Never ☐ Always

9. Have you had sex for money, drugs or something you needed?
☐ Yes ☐ No

10. When was the last time you were tested for HIV?
☐ _____ ☐ Never

11. Did you receive your results? ☐ N/A
☐ Yes ☐ No

12. Would you like more information about HIV where to get tested / treated?
☐ Yes ☐ No

Please check what was provided to Person Served below:
☐ HIV Fact Sheet ☐ Discussion Only ☐ Referral ☐ Viral Hepatitis Information
☐ Other STI Information ☐ Other: _____

Other Notes / Recommendations:

Person's Name (First MI Last):	**Record #:**

Person's Signature (Optional, if clinically appropriate)	**Date:**	**Parent/Guardian Signature** (If appropriate):	**Date:**
Clinician/Provider - Print Name/Credential:	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Clinician/Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**
Psychiatrist/MD/DO (If required):	**Date:**		