HIV Intake Form

Name:	Date of Birth: / /

For the following questions please answer to the best of your ability, check the box which best applies to you, and clearly fill out any question which require a written answer. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. How were you infected with HIV / AIDS?

☐ Male to Male sexual contact
☐ Injection Drug Use
☐ Hemophilia / Coagulation Disorder
☐ Heterosexual Contact
☐ Perinatal Transmission
☐ Undetermined / Unknown, risk not reported or identified
☐ Recipient of Transfusion of Blood, Blood Components, or Tissue
☐ Other: ____

2. Month/Year Diagnosis with HIV /	**3. In which State were you diagnosed?**

4. Last Viral load:	**5. Last CD4 cell Count:**	**6. Lowest CD4 cell count:**

7. Current HIV Medications:	**8. Previous HIV Medications:**
a. ____________________________________	**a.** _____________________________________
b. ____________________________________	**b.** _____________________________________
c. ____________________________________	**c.** _____________________________________

TO BE COMPLETED DURING VISIT

☐ Client agrees to participate in Case Management Services.
☐ Client elects not to participate in the program at this time.

Case manager's Signature: ____ Date: _______/_______/___________

Client's Signature: ____ Date: _______/_______/___________

Parent or Guardian's Signature: ____ Date: _______/_______/___________