The **Live Your Life Undetectable Comprehensive Intake Assessment** is meant to assist clients and providers with identifying needed community support resources and supportive services that will help clients succeed in their path to durable viral load suppression.

Amida Care understands that it is important to have a full picture of a client in order to provide appropriate clinical support. Demographics and clinical information do not provide the full picture. Clients may have multiple needs that must be addressed to produce the desired clinical results.

Providing nonjudgmental interest in a client's problems through active listening, showing empathy and concern for the client as a unique person fosters trust and commitment to improved engagement in health.

We ask that the assessment is completed in full and all fields are populated.

Once the assessment is complete, please save it and upload it to the Sharefile folder along with the client's other enrollment documents.

DEMOGRAPHICS:

Client Name:	
Client CIN #:	
Client Date of Birth:	
Date that Client Was HIV Diagnosed:	
Client's HIV Risk Factor (Use Ctrl Key to Select All Items that Apply):	Use Ctrl Key to Select ALL Items That Apply MSM Heterosexual Injecting Drug User MSM/IDU Sex with IDU Partner
Client's Languages Read (Use Ctrl Key to Select All Items that Apply):	Use Ctrl Key to Select ALL Items That Apply English Spanish Chinese Japanese French

SOCIAL ASSESSMENT

Highest Grade completed (include GED):	
Employed?	Choose
If YES, Type of Work:	
Marital Status:	None
Describe Type of Housing:	
Would Client Benefit From Housing Services Currently Not in Place?	Choose
If YES, What is The Plan?	
Does The Client have any of the following (Use Ctrl Key to Select Multiple Items that Apply)?	Use Ctrl Key to Select ALL Items That Apply Advanced Directive Durable Power of Attorney Healthcare Proxy Will Trust
Any Evidence of Domestic Violence or Child Abuse?	Choose

If YES, What?	
Is Referral Needed?	Choose
If Already In Program, Specify	
Any Legal Issues?	Choose
If YES, What?	
Is Client On Parole?	Choose
If YES, List Parole Contact Name and Phone # :	
Does Client Need Help with Daily Activities? (e.g.; OT, PT, HHA)	Choose
If YES, Use Ctrl Key to Select Multiple Items that Apply:	Using the Ctrl Key, Select ALL Transportation Needs That Apply Ambulatory Wheelchair Walker Cane
Select ALL Transportation Needs That Apply:	Using the Ctrl Key, Select ALL Transportation Needs The Apply Ambulette Ambulance Liverv
Other Transportation:	
Equipment Needed For Care:	Choose
Would Client Benefit From Transportation Assistance?	Choose
If YES, What is The Plan?	

NUTRITION NEEDS

Height:	
Current Weight:	
Body Mass Index (BMI):	
Preferred/Comfortable Weight:	
Receiving Supplements:	Choose
If YES, Please Specify:	

Receiving Nutritional Assistance?	Choose
If YES, What Type:	
Would Client Benefit From Nutrition Services Not Currently in Place?	Choose
If YES, What is The Plan?	

PAIN MANAGEMENT

Acute/Chronic Pain?	Choose
If YES, is Pain Management Plan in Place?	Choose
If YES, What is The Current Management?	
Would Client Benefit From Pain Management Services Currently Not in Place?	Choose
If YES, What is The Plan?	

FAMILY PLANNING ASSESSMENT

Sexually Active?	Choose
If YES, Use the Ctrl Key to Select ALL That Apply:	If Sexually Active, Use Ctrl Key to Select All That Apply Heterosexual MSM Lesbian Monogamous Multiple Partners
If OTHER, Please Specify:	
If Sexually Active, Does Client Practice Safe Sex?	Choose
Has Client Received Safe Sex Education?	Choose
Is Client Pregnant?	Choose
If YES, Date of Last Menstrual Period (LMP):	
If Pregnant, When is the Baby Due?	

Is Client Trying to Get Pregnant?	Choose
If NO, and Client is sexually active, What Type of Contraception Used by client or client's partner?	
Would Client Benefit From Family Planning/safe sex education/partner notification services that are not already in place?	Choose
If YES, What is The Plan?	

MEDICATION ASSESSMENT/ADHERENCE

Allergies:	
Is The Client on ARV Medications?	Choose
If YES, Percentage of ARV Dose Missed in Last 3 Days:	0%
Has Adherence Been Discussed With Client?	Choose
If Not on Antiretroviral Therapy (ART), Check Reasons (Use Ctrl Key to Select Multiple Items that Apply):	Use Ctrl Key to Select ALL Items That Apply Refused Non-Adherent High CD4 Count Treatment Interruption Due to Toxicity No Treatment Options Other
If Other, not on ART, please Specify:	
Would Client Benefit From Medication Adherence Services (Pill Box, Home Delivery, Home Visit By Nurse) That Are Not Already in Place?	Choose
If YES, What is The Plan?	
Would Client Benefit From Referral?	Choose
If YES, What is The Plan?	
Alternatively, Would Client Benefit From a Clinical Trial?	Choose

MENTAL HEALTH ASSESSMENT

Has Client Ever Been Treated For Psychiatric Reasons?	Choose
If YES, What Type and When?	
Is Client on Medication for Depression?	Choose
If YES, What?	
Does Client Have Little Interest Doing Things?	Choose
Is The Client Feeling Down/Depressed or Hopeless?	Choose
Does The Client Currently Have Anxiety?	Choose
Is The Client Currently on Medication for Anxiety?	Choose
If YES, What Medication?	
Does The Client Have Insomnia?	Choose
If YES, Are They on Insomnia Medication?	Choose
Does The Client Have Appetite Problems?	Choose
If YES, What?	
If Abnormal, Please Specify	
Would Client Benefit From Mental Health Services That Are Not Currently in Place?	Choose
If YES, What is The Plan?	

SUBSTANCE USE ASSESSMENT

Has The Client Had Issue With Substance Abuse?	Choose
If YES, Use Ctrl Key to Select Multiple Items that Apply:	If Client Has Had Substance Abuse Issues, Select ALL That Apply Alcohol Benzodiazepanes Cocaine Crack Cocaine Crystal Meth Heroin Marijuana
Is Client Currently Using?	Choose
If YES, Use Ctrl Key to Select Multiple Items that Apply:	If Client Has Had Substance Abuse Issues, Select ALL That Apply Alcohol Benzodiazepanes Cocaine Crack Cocaine Crystal Meth Heroin Marijuana
Comments:	
Does The Client Smoke or Chew Tobacco?	Choose
If YES, Was Smoking Cessation Discussed?	Choose
Is The Client Enrolled in MMTP?	Choose
If YES, Amount of Methadone Prescribed?	
Has The Client Ever Made Use of Drug Treatment Facilities?	Choose
If YES, Use Ctrl Key to Select Multiple Items that Apply?	If YES, Use Ctrl Key to Select Multiple Items that Apply Inpatient Outpatient
Would Client Benefit From Substance Use Services That Are Not Already in Place?	Choose
If YES, What Is The Plan?	
Date Form Completed:	