

Counselor ID #: _____ Site Location: _____ Opscan ID: _____

Today's Date: _____

Please complete this form – it will help your counselor measure your risk for HIV. If you don't know an answer or feel uncomfortable with a question, leave it blank. Your counselor will review this with you during your session.

Personal Information – Please answer the questions below.

Date of Birth: _____ County Where You Live: _____ Zip Code: _____

Age: 13-19 20-24 25-34 35-49 50 or over

Race & Ethnicity: (Select **ALL** that apply) American Indian/Native Alaskan Asian Black/African American
 Native Hawaiian/Pacific Islander White
 Hispanic/Latinx Non-Hispanic/Latinx

Current Gender Identity: Male Female Trans/Nonbinary

Sex at Birth: Male Female

Sexual Health Information – Please answer questions 1- 11 below.

1. Are you pregnant? Yes No Don't Know N/A

2. Have you ever been tested for HIV? Yes No **Date of Last Test:** _____
 Result: Positive Negative Don't Know

3. Have you ever heard of PrEP or PEP? Yes, PrEP Yes, PEP No

4. Are you currently taking PrEP or PEP? Yes, PrEP Yes, PEP No

5. Have you taken PrEP in the last year? Yes No

6. Were you told by a Local Health Department that you may have been exposed to HIV? Yes No Don't Know

7. Are any of your sex or injection partners HIV+?
 Yes No Don't Know

8. IF you have a sex or injection partner who is HIV+, are they on treatment?
 Yes Don't Know N/A (no HIV+ partners)

9. Have you had an STI in the past 12 months?

	Yes	No	Don't Know
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Have you injected or shot up any drugs in the past 12 months?
 Yes, prescribed to me
 Yes, drugs not prescribed to me
 No

11. IF you've injected or shot up, have you shared needles or equipment?
 Yes No
 Don't inject drugs

Sexual Partner History – Please answer questions 12-17 about your sexual partners.

12. About how many partners have you had in the last 12 months? _____

13. Were any anonymous, or someone you didn't know? Yes No

14. Tell me about your sexual activity for the past 12 months:

My partners were...	Condom use was...			My position(s) were...		
	Always	Sometimes	Never	Vaginal	Anal (top/giving)	Anal (bottom/taking)
Men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trans/Nonbinary Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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15. Do your partners inject or shoot-up any drugs?

Yes No Don't Know

16. Have any of your partners had an STI in the last 12 months?

	Yes	No	Don't Know
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. If your partner(s) have sex with other people, do they have sex with...

Gay/Bi Men Women Trans/Nonbinary individuals Straight Men N/A (No other Partners) Don't Know

Additional Information Please answer questions 18-29 about needs you may have.

18. Do you have health insurance? Yes No

19. If you are HIV positive, are you currently seeing a medical provider for treatment? Yes No N/A

20. Do you have trouble taking a daily medication? Yes No

21. Do you have any mental health concerns? Yes No

22. Do you use drugs or drink alcohol? Yes No

23. Do you have any untreated STIs? Yes No

25. Do you have reliable transportation? Yes No

26. Do you have any immediate housing needs? Yes No

27. Do you feel safe in your relationship? Yes No N/A

28. Does your partner pressure you into having sex? Yes No

29. Do you ever exchange sex for money or drugs or something you need? Yes No

24. What is your current employment status?

Employed, not looking for work Part-time, seeking full-time work Unemployed, looking for work
 Other: _____



STOP HERE. YOU HAVE REACHED THE END OF THE RISK ASSESSMENT.

Section Only Completed by HIV Test Counselor

Client or partners come from an Ohio population prioritized for testing? (see score sheet for list) Y <input type="checkbox"/>		
Considered to be at-risk? (circle)	Y N	Total Risk Score:
If test offered to client with score below 50, justify here:		
OpScan 5 year questions: In past 5 years...		
had sex with woman? <input type="checkbox"/> Y <input type="checkbox"/> N with man? <input type="checkbox"/> Y <input type="checkbox"/> N With trans person? <input type="checkbox"/> Y <input type="checkbox"/> N Injected drugs? <input type="checkbox"/> Y <input type="checkbox"/> N		
Referral provided for:	<input type="checkbox"/> PrEP	<input type="checkbox"/> Linkage to HIV Medical Care
	<input type="checkbox"/> Health Benefits Navigation	<input type="checkbox"/> Medication Adherence Support
	<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> Substance Use Treatment
	<input type="checkbox"/> Housing	<input type="checkbox"/> Transportation
	<input type="checkbox"/> DV/IPV Intervention	<input type="checkbox"/> Employment Services
	<input type="checkbox"/> Perinatal Support	<input type="checkbox"/> PAPI Enrollment
Service provided:	<input type="checkbox"/> Risk Reduction Intervention	<input type="checkbox"/> Linkage to HIV Medical Care
	<input type="checkbox"/> PrEP Navigation	<input type="checkbox"/> Medication Adherence Support
	<input type="checkbox"/> Health Benefits	<input type="checkbox"/> PAPI Enrollment