



**ND CARES PROGRAM CLIENT ASSESSMENT**  
 NORTH DAKOTA DEPARTMENT OF HEALTH  
 SFN 58590 (10-08)

Date of Assessment	Ryan White Identification Number
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**Client Information**

Client's Name	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Telephone Number	
Street Address	City		State	Zip Code
Medicaid Number	Medicare Number			
Race (check one) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American				
Ethnicity (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic				
Marital Status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown <input type="checkbox"/> Child				

**Medical Information**

Medical Diagnosis/Onset Date/Surgeries/Hospitalizations	
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CD4 Count	Viral Load

**Vital Signs**

Blood Pressure	Pulse	Respirations	Temperature	Weight
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**Allergies**

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### Physical Assessment

1. Are there any rashes or lesions?  Yes  No  
Comments \_\_\_\_\_
2. Is the heart rate normal?  Yes  No  
Comments \_\_\_\_\_
3. Are there any heart murmurs?  Yes  No  
Comments \_\_\_\_\_
4. Are there any extra heart beats?  Yes  No  
Comments \_\_\_\_\_
5. Assess breath sounds throughout the lung fields.  
Comments \_\_\_\_\_

### Psycho/Social Assessment

1. Does the client exhibit signs of depression?  Yes  No  
Comments \_\_\_\_\_
2. Does the client have any signs of anxiety?  Yes  No  
Comments \_\_\_\_\_
3. Does the client have any signs of mental illness?  Yes  No  
Comments \_\_\_\_\_

### Medications

Are you currently taking:

1. Medication for HIV treatment?  Yes  No  
Comments \_\_\_\_\_
2. Medication for conditions other than HIV?  Yes  No  
Comments \_\_\_\_\_
3. Medication from "over the counter?"  Yes  No  
Comments \_\_\_\_\_
4. Herbal remedies?  Yes  No  
Comments \_\_\_\_\_

### Immunizations/Tests – History of Childhood and Adult Vaccinations

Have you had the following immunizations? Include dates (if known) in comment section.

1. Tetanus/diphtheria  Yes  No  
Comments \_\_\_\_\_
2. Pneumococcal  Yes  No  
Comments \_\_\_\_\_
3. Influenza  Yes  No  
Comments \_\_\_\_\_
4. MMR  Yes  No  
Comments \_\_\_\_\_
5. Hepatitis B  Yes  No  
Comments \_\_\_\_\_
6. Hepatitis A  Yes  No  
Comments \_\_\_\_\_
7. TB Test  Yes  No  
Comments \_\_\_\_\_
8. Hepatitis C Test  Yes  No  
Comments \_\_\_\_\_
9. Do you have a history of a positive PPD?  Yes  No  
Comments \_\_\_\_\_
10. Do you have a history of an abnormal chest x-ray?  Yes  No  
Comments \_\_\_\_\_
11. Chicken pox  Yes  No  
Comments \_\_\_\_\_
12. Is everyone in your household current with their immunizations?  Yes  No  
Comments \_\_\_\_\_

## Review of Systems

Have you experienced any of the following:

13. Weight loss/gain  Yes  No

Comments \_\_\_\_\_

14. Fever  Yes  No

Comments \_\_\_\_\_

15. Night sweats  Yes  No

Comments \_\_\_\_\_

16. Dysuria  Yes  No

Comments \_\_\_\_\_

17. Nausea/vomiting  Yes  No

Comments \_\_\_\_\_

18. Loss of appetite  Yes  No

Comments \_\_\_\_\_

19. Genital/anorectal lesions, discharge and/or tenderness  Yes  No

Comments \_\_\_\_\_

### ***For women only.***

20. Have you experienced menstrual irregularities?  Yes  No

Comments \_\_\_\_\_

21. Have you ever been pregnant?  Yes  No

Comments \_\_\_\_\_

22. When was your last menstrual period? \_\_\_\_\_

Comments \_\_\_\_\_

23. When was your last Pap smear? \_\_\_\_\_

24. Was your Pap smear cervical or anal? \_\_\_\_\_

25. Do you have a history of abnormal Pap smears?  Yes  No

Comments \_\_\_\_\_

## Health Maintenance

1. Have you had previous primary care?  Yes  No  
Comments \_\_\_\_\_
2. Have you had previous dental care?  Yes  No  
Comments \_\_\_\_\_
3. Have you had previous eye care?  Yes  No  
Comments \_\_\_\_\_

## Social – Start with less threatening areas to establish communications and build rapport.

1. Do you currently use alcohol?  Yes  No  
Comments \_\_\_\_\_
2. Do you currently use tobacco?  Yes  No  
Comments \_\_\_\_\_
3. Have you ever used illegal drugs?  Yes  No  
Comments \_\_\_\_\_
4. Are you currently using illegal drugs?  Yes  No  
a. How do you use them (inject, snort, smoke, etc.) \_\_\_\_\_  
b. Do/did you share your equipment with others?  Yes  No  
Comments \_\_\_\_\_
5. Are you sexually active?  Yes  No  
a. Do you have sex with men?  Yes  No  
b. Do you have sex with women?  Yes  No  
c. Do you have sex with both men and women?  Yes  No  
d. Do you have sex with an intravenous drug user (IDU)?  Yes  No  
e. How do you protect yourself and others from STDs? \_\_\_\_\_  
\_\_\_\_\_
6. Have you experienced violence, including forced sex and domestic abuse?  Yes  No  
Comments \_\_\_\_\_
7. Who have you told about your diagnosis? \_\_\_\_\_  
a. How are they helping you with your diagnosis? \_\_\_\_\_  
\_\_\_\_\_

**Physician's Information**

Physician's Name		Telephone Number	
Street Address	City	State	Zip Code

**Other**

Emergency Contact Name		Telephone Number	
Street Address	City	State	Zip Code
Does this client live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does this client have a willing and able caregiver available? <input type="checkbox"/> Yes <input type="checkbox"/> No			