



SYRINGE EXCHANGE CLIENT ENROLLMENT FORM

NORTH DAKOTA DEPARTMENT OF HEALTH

DIVISION OF DISEASE CONTROL

Revised 11/2018

This form is optional and not required. Please do not include any personally identifying information on this form.

Enrollment Information

Date:	Agency/Site Name:	Interviewer:
Enrollment Type: <input type="checkbox"/> First Enrollment <input type="checkbox"/> Re-Enrollment	Participant Code:	

Client Demographics

Current Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> M2F Transgender <input type="checkbox"/> F2M Transgender <input type="checkbox"/> Refused <input type="checkbox"/> Other _____		
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Refused <input type="checkbox"/> Other _____		
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino	Current Zip Code	County of Residence
Current Living Status: <input type="checkbox"/> Permanent Residence <input type="checkbox"/> Homeless <input type="checkbox"/> Shelter <input type="checkbox"/> Car/Vehicle <input type="checkbox"/> Refused <input type="checkbox"/> Other _____		

Syringe Services Assessment

How long have you been injecting? _____ months/years	How often do you inject? _____ times per day/week
Have you been incarcerated in the last 90 days?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
What are the ways you use drugs? Select all that apply. <input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Swallow <input type="checkbox"/> Snort <input type="checkbox"/> Suppositories <input type="checkbox"/> Other _____	Which of the following have you used in the last 30 days? <input type="checkbox"/> Heroin <input type="checkbox"/> Methamphetamine/Speed <input type="checkbox"/> Crack/Cocaine <input type="checkbox"/> Methadone* <input type="checkbox"/> Cannabis/Marijuana <input type="checkbox"/> Suboxone/Subutex* <input type="checkbox"/> Spice <input type="checkbox"/> Benzodiazepines (Benzos, Ativan, Xanax, etc.) <input type="checkbox"/> Prescription Pain Medication* (codeine, Vicodin, OxyContin, Hydrocodone, Percocet, Fentanyl, etc.) <input type="checkbox"/> Other _____ *Not As Prescribed
During the last 30 days did you share or reuse any of the following? <input type="checkbox"/> Cookers/Water <input type="checkbox"/> Syringes/Needles <input type="checkbox"/> Cottons/Filters <input type="checkbox"/> Other _____	If you have shared or reused any of the equipment listed previously, how often would you say that occurred? <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always
Have you ever overdosed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	If you have overdosed, when was the last time?
Have you ever used Narcan/Naloxone? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	If you have used Narcan/Naloxone, when was the last time?
During the last year, have you received any substance abuse treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you consider discussing substance use treatment options today? <input type="checkbox"/> Yes <input type="checkbox"/> No
Since participating in the SSP, have you been arrested on a drug related charge? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long did you serve? _____ days/months
Have you used SSP provided Narcan/Naloxone to save your life or the life of someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many lives were saved? _____

Medical Services Assessment

Have you ever been tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused If yes, when: _____	Have you ever been tested for Hepatitis C? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused If yes, when: _____
What was the result? <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Refused	What was the result? <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Refused
How many people have you had sex with in the past 12 months? <input type="checkbox"/> 0 <input type="checkbox"/> 1 - 2 <input type="checkbox"/> 3 - 5 <input type="checkbox"/> >5	My sex partner(s) are: (check all that apply) <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Transgender Individuals
How often do you use condoms/other protection? <input type="checkbox"/> Always <input type="checkbox"/> Most of the Time <input type="checkbox"/> Not that Often <input type="checkbox"/> Never	Have you ever had _____ sex: (check all that apply) <input type="checkbox"/> Vaginal <input type="checkbox"/> Anal (receptive) <input type="checkbox"/> Anal (insertive) <input type="checkbox"/> Oral
What activities/behaviors do you do or have done in the past that might place you at risk for HIV/STI/Hepatitis? <input type="checkbox"/> Multiple sex partners <input type="checkbox"/> Use dating apps to meet sex partners <input type="checkbox"/> Had anonymous sex <input type="checkbox"/> Tattooing: non-sterile settings (i.e. home/ jail) <input type="checkbox"/> Received body piercing in non-sterile setting <input type="checkbox"/> Were or had sex partner infected with STI <input type="checkbox"/> Victim of human trafficking	<input type="checkbox"/> Had sex under the influence of drugs/alcohol <input type="checkbox"/> Shared straws while snorting drugs <input type="checkbox"/> Had sex in exchange for money/drugs/food/etc. <input type="checkbox"/> Victim of sexual assault <input type="checkbox"/> Had a blood transfusion before 1992 <input type="checkbox"/> Family member in household has HCV <input type="checkbox"/> Received clotting factor before 1987 <input type="checkbox"/> Had sex with Hepatitis C positive individual