



Risk Assessment Questionnaire

A risk assessment must be completed on all clients to determine risk factors and history. Please complete this form by filling in your answer or checking the appropriate box. All information is CONFIDENTIAL and will help us meet your needs.

Today's Date: ____ / ____ / ____

Last Name: _____ First Name: _____

Date of Birth (mm/dd/yyyy) ____ / ____ / ____ Age: ____ Phone: (____) ____ - ____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Sex Assigned at Birth: Male Female Intersex Prefer not to answer

Gender Identity: Man Woman Transgender

Self Describe: _____

Prefer not to answer

Race: White Black Am. Indian/Alaska Native Asian/Pacific Islander Other Unknown

Ethnicity: Hispanic Non-Hispanic Other

1. **How many people have you had sex with during your lifetime?**

0 1-5 6-10 11-20 20+

2. **How many people have you had sex with in the last 3 months?** _____

3. **My sex partners are (check all that apply):** Men Women Both

4. **Do you participate in:** Anal sex YES NO

Oral sex YES NO

Vaginal sex YES NO

5. **Have you or your sexual partner(s) had other sexual partners in the past year?**

YES NO Not sure

6. **When you have sex, do you use a condom or other barrier:**

Always Most of the time Not that often Never

7. **Have you ever had sex with a male partner who has had sex with another male?**

YES NO Not sure

8. **Have you ever *paid* for sex or traded sex for drugs, food, clothing, etc.?** YES NO

9. Have you ever *been paid* for sex or traded sex for drugs, food, clothing, etc.? YES NO
10. Have you ever had sex while high on drugs or alcohol? YES NO Not sure
11. Have you ever had sex with someone infected with (check all that apply):
 Hepatitis B Hepatitis C HIV/AIDS STD Not sure
12. Have you ever had sex with someone who injected drugs? YES NO Not sure
 If YES, was it: (Check all that apply) Current sex partner Past sex partner
13. Have you ever injected drugs? YES NO
 If YES, did you ever share needles, syringes, or “works”? YES NO
14. Have you ever snorted drugs (i.e., cocaine, speed, heroin, ecstasy, meth)? YES NO
 If YES, have you ever shared straws while snorting? YES NO
15. Have you ever had a sexually transmitted infection? YES NO (skip to #17)
16. Check any disease or condition you have had (check all that apply):
 Syphilis Genital/Sex Warts Gonorrhea (clap) Herpes
 HIV Chlamydia Trichomonas (trich) Hepatitis A
 Hepatitis B Hepatitis C Women – infection in your tubes/womb (PID)
 Men - burning or drip from penis (not gonorrhea or chlamydia)
17. Have you ever been in jail, prison, or a detention center? YES NO
18. Have you ever had a tattoo? YES NO
19. Have you ever had body piercing (other than your ears)? YES NO
20. Have you ever been tested for HIV? YES NO Not sure
21. Have you ever been tested Hepatitis C? YES NO Not sure
22. Are you pregnant or considering becoming pregnant? YES NO Not sure
23. Have you or your sexual partner(s) injected drugs or other substances and/or shared needles with another person?
 YES NO Not sure
24. Have you or your sexual partner(s) received a blood transfusion or blood products before 1985?
 YES NO Not sure
25. Have you been the victim of nonconsensual intercourse or sexual abuse?
 YES NO Prefer not to answer

26. **Have you travel out of the country in the last 12 months?** YES NO

If **YES**, where did you travel and when?

Location Dates

Location Dates

Location Dates

27. **Have you traveled out of state in the last 12 months?** YES NO

If **YES**, where did you travel and when?

Location Dates

Location Dates

Location Dates

28. Please list any additional concerns you may have at this time: _____

