

GROUP SELF ADMINISTERED QUESTIONNAIRE (GSAQ)



Shade Circles Like This--> ●

When writing letters or numbers, place one character in each box. Please print carefully and avoid the edges of the box. For letters, use only capitals. **PLEASE USE BLACK PEN ONLY**

Not Like This--> ~~⊗~~ ⊙

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

1	2	3	4	5	6	7	8	9	0
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SOME BACKGROUND INFORMATION ABOUT YOU

First Name Initial: Last Name Initial:

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What is your date of birth? (mm/dd/yy)

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What is the zip code for your home?

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In what country were you born?

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Have you been incarcerated in the last 12 months or since the last session? Yes No

Are you a sex worker? Yes No

What gender do you consider yourself? (choose only one gender)

- Male
- Female
- Transgender: M to F
- Transgender: F to M

Other, specify:

What was your gender at birth? (choose only one)

- Male Female

If female, are you pregnant?

- Yes No Don't Know

If pregnant, are you in prenatal care?

- Yes No

Which of the following comes closest to your sexual orientation? (choose only one)

- Heterosexual/straight Gay or lesbian
- Bisexual Declined/Refused

Other, specify:

What type of health insurance do you currently have? (choose all that apply)

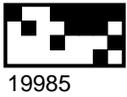
- No coverage Medi-Cal (Medicaid)
- Private Indian Health Service
- Military Other, specify:
- Medicare

What is your homeless status? (choose only one)

- Not Homeless/Has a permanent living situation indoors
- Homeless, living outdoors
- Homeless, staying in a shelter or transitional housing where other services are being provided
- Homeless, sleeping in a car or temporary indoor situation without additional services
- Homeless, but cannot or will not give more detail
- Unable or unwilling to give any information as to homeless status

What is your race/ethnicity? (mark all that apply)

- Black/African-American Asian
- American Indian/Alaska Native White
- Hispanic/Latino(a) Don't Know
- Native Hawaiian/Pacific Islander Declined
- Other race, specify:



SEXUAL BEHAVIOR HISTORY

Did you have vaginal or anal sex in the last 12 months or since the last session? Yes No
If yes, please complete questions below. If NO, SKIP to page 3.

If this is your **FIRST SESSION**, complete the section labeled "In the Last 12 months".

If this is your **FINAL SESSION** or **30 DAY FOLLOW UP**, complete the section labeled "Since the Last Session".

The section labeled "Always used condoms during sex activity" should be completed for ALL Sessions.

**COMPLETE THIS COLUMN IF
THIS IS YOUR FIRST SESSION**

**COMPLETE THIS COLUMN
AT ALL OTHER SESSIONS**

SEX ACTIVITY	LAST 12 MONTHS			SINCE THE LAST SESSION			ALWAYS COMPLETE
	All Partners in Last 12 Months			All Partners Since Last Session			Always used condoms during sex activity
	Male	Female	Transgender	Male	Female	Transgender	
Oral Sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Vaginal Sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anal Sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exchanged sex for drugs/money/ something needed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sex while intoxicated/ high on drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sex with a partner who is an IDU	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sex with a partner who is HIV+	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sex with a partner whose HIV status is unknown	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sex with a partner who exchanges sex for drugs/money/etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sex with anonymous partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FOR FEMALE CLIENTS ONLY: Sex with a male or transgender partner who has sex with other men	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>

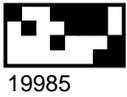
How many partners have you had vaginal or anal sex with in the past 30 days? (0-999)

Male Female Transgender

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SEXUAL HEALTH HISTORY

Were you diagnosed with an STD or Hepatitis in the last 12 months or since the last session? (mark all that apply)

- No STDs/Hepatitis, Chlamydia, Genital Herpes (HSV), Syphilis (syph, the pox, lues), Human Papilloma Virus (HPV), Hepatitis C (HCV), Gonorrhea (GC, clap, drip), Trichomoniasis (trich), Other STD, specify: [text box], Hepatitis A (HAV), Hepatitis B (HBV)

Have you EVER been vaccinated for either of the following? (choose all that apply):

- Hepatitis A, Hepatitis B

How many times have you tested for HIV?

(enter "0" if you have never tested before today)

[] [] Mark here if you Decline/Refused to Answer

What was the date of your last HIV test result received? (mm/yy)

[] [] / [] []

If you have tested before, what was the last HIV test result you received? (choose only one)

- Negative, Preliminary Positive (no confirmatory result received by client), Positive, Inconclusive, discordant, invalid, Never received a result, Declined/Refused to answer

HIV Medical Care

If you are HIV+, complete the following questions. If this is the FIRST session, answer the question for the past 6 months. For all other intervention sessions or follow up, answer the following questions in terms of 'since last session':

How many times did you see a health care provider for your HIV? Please don't include times when you had an emergency room visit or a hospital admission, or only had a lab test done.

If first session, # in past 6 months. All other sessions, # since last session.

Enter # from 0-199

[] [] [] Mark here if you Decline/Don't Know

Date of last HIV medical care visit? (mm/yy)

[] [] / [] []

HIV Medical Care:

(If you tested positive today and were not referred this visit, why?)

- Already in care, Declined care



SUBSTANCE USE HISTORY

The following questions are about recreational street drugs that you may have used in the last 12 months or since the last session but does NOT include any drugs taken under a doctor's order or hormones.

In the last 12 months or since the last session, have you injected any substance (drugs, hormones, insulin, vitamins, etc.) AND shared needles or works?

Yes No

Have you EVER injected any substance (drugs, hormones, insulin, vitamins, etc) AND shared needles or works?

Yes No

In the last 12 months or since the last session, have you used any of the following substances?

No alcohol or drug use Declined/Refused

If no alcohol or drug use, please skip this section. If yes, please mark all that apply.

Table with 3 columns: Did you use any of the following substances(s)?, If yes, did you have sex while using the drug?, Did you inject the drug? Rows include Alcohol, Methamphetamine, Cocaine, Crack, Heroin, and Other Drug.

Please continue on next page





SELF-PERCEIVED RISK AND KNOWLEDGE

Please indicate to what extent you agree or disagree with the statements below:

AIDS is now nearly cured. (choose only one)

- Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree

Being HIV-positive isn't that big of a deal now that treatments are better. (choose only one)

- Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree

If you are HIV-, what do you think your chances of getting HIV are? If you are HIV+, what do you think your chances of transmitting HIV are? (choose only one)

- Very Likely, Likely, Neither Likely nor Unlikely, Unlikely, Very Unlikely

I am able to use a condom under any situation so that I don't get or spread HIV. (Such as when I am drunk or high or when my partner doesn't want to use condoms) (choose only one)

- Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree

For the next set of questions, please indicate if you believe the statement is true or false:

Table with 4 columns: Statement, True, False, Don't Know. Rows include statements about pulling out the penis, anal sex, HIV signs, HIV vaccine, deep kissing, and multiple partners.

Thank you! All of your responses will remain confidential.

Your answers will help our agency to better serve you. If you have any questions or concerns as a result of these questions or your answers, you may talk with your group facilitator.



GROUP SELF ADMINISTERED QUESTIONNAIRE (GSAQ)



ADMINISTRATIVE USE ONLY

Program ID: [][][][]

Site ID: [][][][]

Time of Encounter:

[] : []

- AM
PM

Session: (choose only one)

- Session 1
Final Session
30 Day Follow Up

Complete this section at the first session only:

How was client referred? (choose only one)

- Agency
Friend/Family
HC/PI
Self
Partner
Don't Know
Other, specify:

Session Date: (mm/dd/yy)

[][] / [][] / [][]

Complete this section if client is unaware of their status or wishes to be tested. Place a test lab sticker in the box if client tests today:

Testing Referral: (choose only one)

- Tested at encounter
Referred for testing
Declined/refused testing
No testing referral



Place Test Lab Sticker #1 Below

[]

***If client was referred from an agency, which program?

- HCT
HC/PI
HE/RR
Partner Services
CRCS
Intake
Outreach Encounter
Other
Don't Know

Referrals: (choose all that apply)

- No referrals provided

Risk/Harm Reduction

- Comprehensive risk counseling (CRCS)
Prevention support group
HIV education & prevention services
Prevention skill development
Follow-up HIV counseling
Individual psychotherapy/counseling

Other Referrals

- HCV medical services
Reproductive services
Post exposure prophylaxis (PEP)
STD testing & treatment
Hepatitis testing/vaccination
TB testing & treatment
General medical services
Other referral, specify:
Social services

Positive Referrals

- HIV medical care
HIV case management

Substance Use Services

- Alcohol/Drug Treatment
Harm reduction services
Syringe exchange program (SEP)