

PATHWAYS TO WELLNESS/ACP

INITIAL INTAKE FORM

Welcome to Pathways to Wellness. Please complete the following form in detail. All information on this form is **confidential** and will be seen only by our staff unless you give written authorization to release information.

All the information requested on this page is REQUIRED by our funder, the Department of Public Health and is mandatory for inclusion into the program.

First Name: _____ MI: _____ Last Name: _____

Address _____

City: _____ State: _____ Zip: _____

Housing Permanent Non-permanent Institution Other

Phone: day _____ eve _____ cell _____

We typically confirm treatment appointments by phone a day in advance.

What is your preferred phone number for confirmation calls? (circle one) **Day / Eve / Cell**

Mandatory: An anonymous client code will be used in your file and is comprised of:

_____/_____/_____-_____-_____-_____-

First 3 letters of your mother's FIRST name **Date of Birth** **Last 4 digits of your Social Security #**

Gender: Male Female Transgender Intersex

Emergency Contact: _____ Contact Phone: _____

Primary Physician & Hospital affiliation: _____

Physician's Phone: _____

How many hours do you work or volunteer/week? _____ Occupation: _____

Email: _____

We will never sell or transfer your information to third parties. We would like to send you our newsletter or information by email. May we? () Yes () No May we by mail? () Yes () No

Referral Information: Please Check One

- Counseling/testing Site
- AIDS Service Organization
- Justice system
- Case Manager/Client Adv
- Other Pathways Location
- Substance Abuse Clinic
- Health care provider _____
- Insurance provider _____
- Saw presentation: Where? _____
- Friend _____
- Advertisement: Where? _____
- Event: Which One? _____
- Saw Article: Where? _____
- Internet: Search Engine _____
- Other Website _____
- Other _____

Do you have a Case Manager? ____ Yes ____ No

If yes, please tell us his/her name _____

Please select ALL that apply (you **MUST** select at least one)

- White
- African-American/Black
- Asian
- Native Hawaiian/Pacific Islander
- American Indian/Alaskan native
- Unknown/unreported

In addition to your choice above, you may select additional groups below:

- African
- Haitian
- Cape Verdean
- Portuguese
- Brazilian

Ethnicity: Required in this format by our state and federal funds providers

Do you have Latino ancestry No Yes Specify: _____ Unknown

Primary Language: Is English your second language: Yes No

- English
- Portuguese
- Haitian/Creole
- Spanish
- Creole (Cape Verdean)
- Southeast Asian
- French
- American Sign Language
- Other _____

If you would like us to know how you identify:

O gay/MSM O straight O transgender O Lesbian/WSW O bisexual O questioning

HAVE YOU EVER BEEN TESTED FOR:

- HIV? Yes No Results: HIV+ HIV- Unknown
- Tuberculosis? Yes No Results: Positive Negative Chronic Carrier Unknown
- Hepatitis A? Yes No Results: Positive Negative Unknown
- Hepatitis B? Yes No Results: Positive Negative Chronic Carrier Unknown
- Hepatitis C? Yes No Results: Positive Negative Unknown
- If Hepatitis C: Liver function results: Normal Abnormal Unknown

WESTERN MEDICAL DIAGNOSIS

Please check off any Western Diagnosis you have now or have had in the past:

- | | | |
|--|---|--|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> stroke/heart attack | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> toxoplasmosis | <input type="checkbox"/> peripheral neuropathy | <input type="checkbox"/> epilepsy/ seizures |
| <input type="checkbox"/> cryptosporidium | <input type="checkbox"/> dementia | <input type="checkbox"/> attention deficit disorder |
| <input type="checkbox"/> eating disorder | <input type="checkbox"/> arthritis | <input type="checkbox"/> wasting syndrome |
| <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> carpal tunnel syndrome | <input type="checkbox"/> allergies to metal |
| <input type="checkbox"/> chronic fatigue syndrome | <input type="checkbox"/> pacemaker | <input type="checkbox"/> candidiasis |
| <input type="checkbox"/> shingles | <input type="checkbox"/> CMV infections | <input type="checkbox"/> bacterial septicemia |
| <input type="checkbox"/> endocarditis | <input type="checkbox"/> recurrent salmonella | <input type="checkbox"/> pelvic inflammatory disease (PID) |
| <input type="checkbox"/> pneumonia: what type _____ | | <input type="checkbox"/> STD : what type _____ |
| <input type="checkbox"/> cancer: what type _____ | | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> mental health issues: what type _____ | | |
| <input type="checkbox"/> Allergies: what drugs or substances _____ | | |

DIAGNOSTIC QUESTIONS

Please indicate all symptoms below that you have experienced **within the past 30 days**. Please circle according to the severity of your symptoms

L=Light M=Medium S=Strong

If you do not have the symptom, do not circle anything.

HEAD, EYES, EARS, NOSE, THROAT

- | | | |
|-----------------------------|-----------------------------|--------------------------|
| L M S sinus problems | L M S nose bleeds | L M S dry mouth |
| L M S difficulty swallowing | L M S sore throat/mouth | L M S thrush/leukoplakia |
| L M S headaches | L M S dental/gum | L M S thirst |
| L M S ear/hearing problems | L M S vision problems | L M S dizziness |
| L M S sneezing/runny nose | L M S other (specify) _____ | |

RESPIRATORY

- | | | |
|-----------------------------|--------------------------|------------------|
| L M S shortness of breath | L M S pain w/deep breath | L M S phlegm |
| L M S blood in sputum | L M S wheezing | L M S cough |
| L M S bronchitis | L M S frequent colds | L M S chest pain |
| L M S other (specify) _____ | | |

GASTROINTESTINAL

- | | | |
|------------------------|-----------------------------|----------------|
| L M S loss of appetite | L M S abdominal cramps | L M S nausea |
| L M S gas/bloating | L M S constipation | L M S diarrhea |
| L M S weight loss | L M S hemorrhoids | L M S vomiting |
| L M S heartburn | L M S other, specify: _____ | |
| L M S jaundice | | |

CARDIOVASCULAR

- | | | |
|--------------------------|---------------------------|--------------------|
| L M S low blood pressure | L M S high blood pressure | L M S palpitations |
|--------------------------|---------------------------|--------------------|

Please list all HIV – medications you currently use:

- Check if no current western medications used
- Check if currently taking HIV medications (Please check off all current medications below)
- Check if currently on a Structured Treatment Interruption (“drug holiday”)

Adherence Level: Overall in the past month, have you taken your prescribed medications:
 Almost never Less than 50% of the time 50% of the time Routinely Unknown

Anti-viral drugs

- | | | | |
|---|--|---|----------------------------------|
| <input type="checkbox"/> AZT (Retrovir) | <input type="checkbox"/> 3TC (EpiVir) | <input type="checkbox"/> ddc (Hivid, zalcitabine) | <input type="checkbox"/> Emtriva |
| <input type="checkbox"/> ddI (Videx) | <input type="checkbox"/> d4T (Zerit) | <input type="checkbox"/> Interferon | <input type="checkbox"/> Truvada |
| <input type="checkbox"/> Interleukin - 2 | <input type="checkbox"/> Immunoglobulin IV | <input type="checkbox"/> Ziagen (abacavir) | |
| <input type="checkbox"/> Combivir (AZT & 3TC in one pill) | | <input type="checkbox"/> Other_____ | |
| <input type="checkbox"/> Adefovir | <input type="checkbox"/> Trizivir | <input type="checkbox"/> Viread (tenofovir) | |

Protease Inhibitors:

- | | | |
|---|---|--|
| <input type="checkbox"/> Ritonavir
(Norvir) | <input type="checkbox"/> Saquinavir
(Invirase) | <input type="checkbox"/> Indinavir
(Crixivan) |
| <input type="checkbox"/> Nelfinavir
(Viracept) | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Agenerase (amprenavir) | <input type="checkbox"/> Fortovase | <input type="checkbox"/> Kaletra <input type="checkbox"/> Reyataz (atazanavir) |

Anti-Retrovirals

- | | | |
|--------------------------------------|---------------------------------|-------------------------------------|
| <input type="checkbox"/> Hydroxyurea | <input type="checkbox"/> Fuzeon | <input type="checkbox"/> Other_____ |
|--------------------------------------|---------------------------------|-------------------------------------|

Anti-Depressants/Anti anxiety/Sleep

- | | | |
|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Prozac | <input type="checkbox"/> Elavil | <input type="checkbox"/> Zoloft |
| <input type="checkbox"/> Wellbutrin | <input type="checkbox"/> Klonopin | <input type="checkbox"/> Remeron |
| <input type="checkbox"/> Desipramine | <input type="checkbox"/> Celexa | <input type="checkbox"/> Effexor |
| <input type="checkbox"/> Trazadone | <input type="checkbox"/> Luvox | <input type="checkbox"/> Clonazepam |
| <input type="checkbox"/> Nortriptylene | <input type="checkbox"/> Risperdal | <input type="checkbox"/> Other:_____ |

Secondary Conditions:

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Acyclovir (Zovirax) | <input type="checkbox"/> Bactrim | <input type="checkbox"/> Clindomycin (Biaxin) |
| <input type="checkbox"/> Fluconazole (Diflucan) | <input type="checkbox"/> Foscarnet | <input type="checkbox"/> Dapsone |
| <input type="checkbox"/> Pentamidine | <input type="checkbox"/> Ganciclovir | <input type="checkbox"/> Lomotil |
| <input type="checkbox"/> Itraconazole | <input type="checkbox"/> Leucovirin | <input type="checkbox"/> Mepron |
| <input type="checkbox"/> Zithromax | <input type="checkbox"/> Famvir | <input type="checkbox"/> Famciclovir |
| <input type="checkbox"/> Gemfibrozil | <input type="checkbox"/> Ethambutol | <input type="checkbox"/> Other _____ |

Reverse Transcriptase Inhibitors:

- | | | |
|--|---|--|
| <input type="checkbox"/> Viramune (nevirapine) | <input type="checkbox"/> Rescriptor (delavirdine) | <input type="checkbox"/> efavirenz (DMP or Sustiva or EFV) |
|--|---|--|

Other:

- | | | | |
|--|------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Multi vitamin | <input type="checkbox"/> HRT | <input type="checkbox"/> Immodium | <input type="checkbox"/> Other _____ |
|--|------------------------------|-----------------------------------|--------------------------------------|

WESTERN MEDICATIONS

Please list any medications not included on page 5:

I do not take any Western medications, supplements or herbs

<u>Medication/Supplement/Herb</u>	<u>Used to treat</u>	<u>Side-Effects Experienced</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____

Client Signature: _____ **Date:** _____

ADMINISTRATIVE USE ONLY

Referrals needed for: _____

Referrals made to: _____

Misc: _____

Reviewing Acupuncturist: _____ *Print Name:* _____

Date: _____

Weight: _____

TREATING PRACTITIONER SHOULD GENERATE TREATMENT PLAN