

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.

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: Our public funds providers require that clients be assigned a client code. It is comprised of:

First 3 letters of your mother's FIRST name Date of Birth Social security number

Gender: Male Female Transgender Intersex

Emergency Contact: _____ Contact Phone: _____

Primary Physician & hospital affiliation: _____

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
- Physician/P.A./N.P./Nurse Justice system Saw presentation: where? _____
- Case Manager/Client Adv Other Pathways Location Other _____
- Substance Abuse Clinic Friend

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:

- 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:

gay/MSM straight transgender Lesbian/WSW bisexual questioning

HAVE YOU EVER BEEN TESTED FOR:

HIV? Yes No Results: HIV+ HIV- Unknown

Tuberculosis? Yes No Results: Positive Negative Chronic Carrier

Hepatitis A? Yes No Results: Positive Negative

Hepatitis B? Yes No Results: Positive Negative Chronic Carrier

Hepatitis C? Yes No Results: Positive Negative

If Hepatitis C: Results of liver function tests Normal Abnormal

WESTERN MEDICAL DIAGNOSIS

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

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

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CARDIOVASCULAR

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

GENITO-URINARY

L M S frequent urination L M S night urination L M S impotence

L M S low sex drive L M S pain L M S edema

L M S genital sores L M S genital warts

L M S other, specify _____

MUSCULAR/SKELETAL

L M S muscle/joint pain L M S back pain L M S weakness

L M S pain, tingling or numbness in arms, legs, fingers, toes/ neuropathy

L M S stiff neck/shoulders L M S other, specify _____

NEUROLOGICAL/PSYCHOLOGICAL

L M S depression L M S anxiety L M S fear

L M S irritability/anger L M S disorientation L M S forgetfulness

L M S tremors L M S insomnia L M S seizures

L M S poor concentration L M S bipolar

L M S other, specify _____

SKIN/HAIR/NAILS

L M S itchy/painful rashes L M S fungus L M S shingles

L M S psoriasis/eczema L M S mole changes L M S cold sores

L M S new KS L M S hair loss L M S acne

L M S bleed/bruise easily L M S other _____

OTHER SYMPTOMS

L M S fever over 100 L M S night sweats L M S fatigue

L M S swollen lymph nodes L M S chills L M S day sweats

L M S glucose intolerance L M S lipodystrophy/fat redistribution

L M S other _____

GYNECOLOGICAL/OBSTETRICS

L M S yeast infections L M S menstrual cramps L M S clots

L M S pelvic infections L M S spotting L M S PMS

L M S mid-cycle pain L M S irregular periods L M S no periods

L M S vaginal discharge L M S vaginal pain/itching L M S hot flashes

L M S Other _____

Menstrual Info: ____ days bleeding ____ day cycle date last period _____

Do you take Hormone Replacement Therapy? O Yes O No

Are you pregnant? O Yes O No O Unknown

Please alert your practitioner if you become pregnant. Your treatment will be modified to support a healthy pregnancy.

Are you in menopause? O Yes O No O Unknown

How many pregnancies have you had? _____ Cesareans? _____

Date last pap smear _____ NORMAL ABNORMAL

Last breast exam _____ NORMAL ABNORMAL

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

Anti-viral drugs

- AZT (Retrovir)
- 3TC (Epivir)
- ddc (Hivid, zalcitabine)
- Emtriva
- ddI (Videx)
- d4T (Zerit)
- Interferon
- Truvada
- Interleukin - 2
- Immunoglobulin IV
- Ziagen (abacavir)
- Combivir (AZT & 3TC in one pill)
- Other _____
- Adefovir
- Trizivir
- Viread (tenofovir)

Protease Inhibitors:

- Ritonavir (Norvir)
- Saquinavir (Invirase)
- Indinavir (Crixivan)
- Nelfinavir (Viracept)
- Other _____
- Agenerase (amprenavir)
- Fortovase
- Kaletra
- Reyataz (atazanavir)

Anti-Retrovirals

- Hydroxyurea
- Fuzeon
- Other _____

Anti-Depressants/Anti anxiety/Sleep

- Prozac
- Elavil
- Zoloft
- Wellbutrin
- Klonopin
- Remeron
- Desipramine
- Celexa
- Effexor
- Trazadone
- Luvox
- Clonazepam
- Nortriptylene
- Risperdal
- Other: _____

Secondary Conditions:

- Acyclovir (Zovirax)
- Bactrim
- Clindomycin (Biaxin)
- Fluconazole (Diflucan)
- Foscarnet
- Dapsone
- Pentamidine
- Ganciclovir
- Lomotil
- Itraconazole
- Leucovirin
- Mepron
- Zithromax
- Famvir
- Fanciclovir
- Gemfibrozil
- Ethambutol
- Other _____

Reverse Transcriptase Inhibitors:

- Viramune (nevirapine)
- Rescriptor (delavirdine)
- efavirenz (DMP or Sustiva or EFV)

Other:

- Multi vitamin
- HRT
- Immodium
- Other _____

WESTERN MEDICATIONS

Please list any medications not included on page 5:

I do not take any Western medications Supplements 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. _____	_____	_____

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: _____ Date: _____

Weight: _____ **Kscore:** _____

TREATING PRACTITIONER SHOULD GENERATE TREATMENT PLAN