

**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 (please select one)  Permanent  Non-permanent  Institution  Other

PHONE \_\_\_\_\_ Day \_\_\_\_\_ Eve \_\_\_\_\_ Cell \_\_\_\_\_

Confirmation calls are made a day in advance of an appointment. What is your preferred phone number for such calls? (check one)

DAY  EVE  CELL

EMAIL \_\_\_\_\_

We will never sell or transfer your information to third parties.

May we send you our newsletter or information by email?  YES  NO May we contact you by mail?  YES  NO

**MANDATORY:** An anonymous client code will be used in your file and is comprised of the following

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
The First 3 Letters of Your Mother's FIRST Name

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Your Date of Birth

\_\_\_\_-\_\_\_\_-\_\_\_\_-\_\_\_\_  
The Last 4 digits of Your Phone Number

**EMERGENCY CONTACT, PRIMARY CARE PHYSICIAN, & HOSPITAL AFFILIATION INFORMATION**

EMERGENCY CONTACT NAME \_\_\_\_\_ CONTACT PHONE \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ HOSPITAL AFFILIATION \_\_\_\_\_

PHYSICIAN'S PHONE \_\_\_\_\_

DO YOU HAVE A CASE MANAGER? (please select one)  Yes  No

IF YES, PLEASE LIST HIS/HER NAME HERE \_\_\_\_\_

**GENDER**

Male  Female  Transgender  Intersex

If you would like us to know how you identify, please select one of the following:

Gay/MSM  Straight  Transgender  Lesbian/WSW  Bisexual  Other \_\_\_\_\_

**ETHNICITY**

Do you have Latino ancestry (please select one)?  NO  YES Please specify \_\_\_\_\_  UNKNOWN

Please select ALL that apply (please 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

**PRIMARY LANGUAGE**

Is English your second language?  YES  NO

English  Portuguese  Haitian/Creole  
 Spanish  Creole (CapeVerdean)  Southeast Asian  
 French  American Sign Language  Other \_\_\_\_\_

How many hours do you work or volunteer/week? \_\_\_\_\_ Please list your occupation \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US? Please Check All that Apply**

- 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 (Please list where) \_\_\_\_\_  Friend \_\_\_\_\_
- Advertisement (Please list where) \_\_\_\_\_  Event (Please list which event) \_\_\_\_\_
- Saw Article (Please list where) \_\_\_\_\_  Internet Search Engine \_\_\_\_\_
- Other Website \_\_\_\_\_  Other \_\_\_\_\_

We rely upon referrals from satisfied clients. The person who referred you will receive a 15% discount card in the mail. You will also receive 15% discount cards for your referrals. Thank you!

**HAVE YOU EVER BEEN TESTED FOR THE FOLLOWING:**

- |                        |  |                                 |                                   |                                   |   |
|------------------------|--|---------------------------------|-----------------------------------|-----------------------------------|---|
| <b>HIV</b>             | <input type="checkbox"/> YES <input type="checkbox"/> NO | <i>Results</i>                  | <input type="checkbox"/> HIV +    | <input type="checkbox"/> HIV -    | <input type="checkbox"/> UNKNOWN  |
| <b>Tuberculosis</b>    | <input type="checkbox"/> YES <input type="checkbox"/> NO | <i>Results</i>                  | <input type="checkbox"/> POSITIVE | <input type="checkbox"/> NEGATIVE | <input type="checkbox"/> CHRONIC CARRIER <input type="checkbox"/> UNKNOWN |
| <b>Hepatitis A</b>     | <input type="checkbox"/> YES <input type="checkbox"/> NO | <i>Results</i>                  | <input type="checkbox"/> POSITIVE | <input type="checkbox"/> NEGATIVE | <input type="checkbox"/> UNKNOWN  |
| <b>Hepatitis B</b>     | <input type="checkbox"/> YES <input type="checkbox"/> NO | <i>Results</i>                  | <input type="checkbox"/> POSITIVE | <input type="checkbox"/> NEGATIVE | <input type="checkbox"/> CHRONIC CARRIER <input type="checkbox"/> UNKNOWN |
| <b>Hepatitis C</b>     | <input type="checkbox"/> YES <input type="checkbox"/> NO | <i>Results</i>                  | <input type="checkbox"/> POSITIVE | <input type="checkbox"/> NEGATIVE | <input type="checkbox"/> UNKNOWN  |
| <b>If Hepatitis C:</b> | <b>Liver function results</b>                            | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | <input type="checkbox"/> UNKNOWN  |   |

**PLEASE FILL OUT THE FOLLOWING INFORMATION REGARDING YOUR HIV/AIDS DIAGNOSIS**

What is your current HIV status?  
 **HIV+ (not AIDS)**                       **HIV+ (AIDS status unknown)**                       **AIDS (CDC defined)**

If you tested positive in the last three months list the date of HIV+ diagnosis \_\_\_\_\_ (Month/Day/Year)  
 If you have converted from HIV to AIDS in the last 3 months please list the date \_\_\_\_\_ (Month/Day/Year)

**Last CD4 count (T cell count)** \_\_\_\_\_                      **CD4 Date** \_\_\_\_\_ (Month/Day/Year)  
**Last Viral Load count** \_\_\_\_\_                      **Load Date** \_\_\_\_\_ (Month/Day/Year)

*Last liver function test results:*                       **Normal**                       **Abnormal**                       **Unknown/Not Tested**

**How do you think you were infected with HIV? [Please check all that apply – required by funds providers]**

Men who have sex with men (MSM)     Perinatal                       Injection drug user     Occupational exposure  
 Women having sex with women (WSW)     Heterosexual                       Bisexual                       Other (specify) \_\_\_\_\_  
 Hemophilia/coagulation disorder     Receipt/transfer of blood, blood components or tissue

Have you ever smoked cigarettes?                       **YES**     **NO**  
 Do you smoke now?                       **YES**     **NO**                      How many per day? \_\_\_\_\_

During the last month, how often did you drink alcohol?  
 **never**                       **<5 drinks/week**                       **5-15 drinks/week**                       **>15 drinks/week**

During the last 12 months have you used street drugs?                       **YES**     **NO**  
 In your opinion, are you currently abusing alcohol or drugs?                       **YES**     **NO**  
 Are you in recovery?                       **YES**     **NO**                      For how long? \_\_\_\_\_  
 Are you currently in a drug/alcohol treatment program?                       **YES**     **NO**  
 Have you ever attempted or seriously thought about suicide?                       **YES**     **NO**  
 Are you currently in therapy/counseling?                       **YES**     **NO**

**CURRENT HEALTH**

**What are the main symptoms/problems you seek treatment for? And how long have you had them?**

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**IN THE PAST 12 MONTHS HAVE YOU REQUIRED ANY OF THE FOLLOWING:**

HOSPITALIZATION	<input type="checkbox"/> YES <input type="checkbox"/> NO	How many days? _____	For what reason? _____
EMERGENCY ROOM VISITS	<input type="checkbox"/> YES <input type="checkbox"/> NO	How many visits? _____	For what reason? _____
HOME CARE SERVICES	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please describe _____	

**Please list any previous surgeries, hospitalizations, and serious illnesses with date below.**

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**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"/> Peripheral Neuropathy             |
| <input type="checkbox"/> Epilepsy/Seizures                     | <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"/> Bacterial Septicemia                      | <input type="checkbox"/> Endocarditis               | <input type="checkbox"/> Pelvic Inflammatory Disease (PID) |
| <input type="checkbox"/> Recurrent Salmonella                  | <input type="checkbox"/> Pneumonia: what type _____                |   |  |
| <input type="checkbox"/> STD: what type _____                  | <input type="checkbox"/> Cancer: what type _____                   |   |  |
| <input type="checkbox"/> Mental Health Issues: what type _____ | <input type="checkbox"/> Allergies: what drugs or substances _____ |   |  |
| <input type="checkbox"/> Other: _____                          |  |   |  |

In general, would you say that your health is (*please circle one*):

- |                  |                  |             |             |             |
|------------------|------------------|-------------|-------------|-------------|
| <b>EXCELLENT</b> | <b>VERY GOOD</b> | <b>GOOD</b> | <b>FAIR</b> | <b>POOR</b> |
| 1                | 2                | 3           | 4           | 5           |

**DIAGNOSTIC QUESTIONS**

Please indicate all symptoms below that you have experienced **at any time in the past**.

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**

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

**RESPIRATORY**

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

**GASTROINTESTINAL**

- |   |                               |                          |                           |
|---|-------------------------------|--------------------------|---------------------------|
| <b>L M S</b> loss of appetite               | <b>L M S</b> abdominal cramps | <b>L M S</b> nausea      | <b>L M S</b> gas/bloating |
| <b>L M S</b> constipation                   | <b>L M S</b> diarrhea         | <b>L M S</b> weight loss | <b>L M S</b> hemorrhoids  |
| <b>L M S</b> vomiting                       | <b>L M S</b> heartburn        | <b>L M S</b> jaundice    |                           |
| <b>L M S</b> other ( <i>specify</i> ) _____ |                               |                          |                           |

**CARDIOVASCULAR**

- |                                 |                                  |                           |
|---------------------------------|----------------------------------|---------------------------|
| <b>L M S</b> low blood pressure | <b>L M S</b> high blood pressure | <b>L M S</b> palpitations |
|---------------------------------|----------------------------------|---------------------------|

**L=Light      M=Medium      S=Strong**  
*If you do not have the symptom, **do not** circle anything.*

**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 stiff neck/shoulders  
 L M S pain, tingling or numbness in arms, legs, fingers, toes/ neuropathy  
 L M S other (specify) \_\_\_\_\_

**NEUROLOGICAL/PSYCHOLOGICAL**

L M S depression      L M S irritability/anger      L M S anxiety      L M S fear  
 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 psoriasis/eczema      L M S fungus      L M S shingles  
 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 (specify) \_\_\_\_\_

**OTHER SYMPTOMS**

L M S fever over 100      L M S swollen lymph nodes      L M S night sweats      L M S fatigue  
 L M S glucose intolerance      L M S chills      L M S day sweats  
 L M S lipodystrophy/fat redistribution      L M S other (specify) \_\_\_\_\_

**GYNECOLOGICAL/OBSTETRICS**

L M S yeast infections      L M S menstrual cramps      L M S PMS      L M S vaginal pain/itching  
 L M S spotting      L M S pelvic infections      L M S mid-cycle pain      L M S irregular periods  
 L M S no periods      L M S vaginal discharge      L M S hot flashes      L M S clots  
 L M S other (specify) \_\_\_\_\_

**MENSTRUAL INFORMATION**

\_\_\_\_\_ days bleeding      \_\_\_\_\_ day cycle      date last period \_\_\_\_\_

Do you take Hormone Replacement Therapy?       YES       NO  
 Are you pregnant?       YES       NO       UNKNOWN

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

Are you in menopause?       YES       NO       UNKNOWN

How many pregnancies have you had? \_\_\_\_\_      How many cesareans? \_\_\_\_\_

Date last Pap smear \_\_\_\_\_      **NORMAL      ABNORMAL**      Last breast exam \_\_\_\_\_      **NORMAL      ABNORMAL**

- 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**

- |  |  |   |   |
|--|--|---|---|
| <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"/> Adefovir        | <input type="checkbox"/> Trizivir          | <input type="checkbox"/> Viread (tenofovir)       | <input type="checkbox"/> Other _____                      |

**Protease Inhibitors**

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

**Reverse Transcriptase Inhibitors**

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

**Anti-Retrovirals**

- Hydroxyurea     
  Fuzeon     
  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"/> 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"/> Foscarnet            | <input type="checkbox"/> Gemfibrozil            |
| <input type="checkbox"/> Ethambutol          | <input type="checkbox"/> Other _____ |   |   |

**Other:**

- Multi vitamin     
  HRT     
  Immodium     
  Other \_\_\_\_\_

**WESTERN MEDICATIONS**

Check here if you do not take any Western medications, supplements or herbs

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

*Client Signature* \_\_\_\_\_

*Date* \_\_\_\_\_

**ADMINISTRATIVE USE ONLY**

*Referrals needed for* \_\_\_\_\_

*Referrals made to* \_\_\_\_\_

*Notes* \_\_\_\_\_

*Reviewing Acupuncturist* \_\_\_\_\_ *Print Name* \_\_\_\_\_

*Date* \_\_\_\_\_

**TREATING PRACTITIONER SHOULD GENERATE A TREATMENT PLAN**