

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 _____

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

EMERGENCY CONTACT, PRIMARY CARE PHYSICIAN, & HOSPITAL AFFILIATION INFORMATION

EMERGENCY CONTACT NAME _____ CONTACT PHONE _____

PRIMARY CARE PHYSICIAN _____ HOSPITAL AFFILIATION _____

PHYSICIAN'S PHONE _____

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

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

- 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:

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

- 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

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.

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):

- | | | | | |
|------------------|------------------|-------------|-------------|-------------|
| EXCELLENT | VERY GOOD | GOOD | FAIR | POOR |
| 1 | 2 | 3 | 4 | 5 |

Please list the MAIN SYMPTOMS (up to *three*) for which you are seeking treatment in the table below.

<p>Please enter <u>SYMPTOM 1 (S1)</u> here</p> <hr/>	<p>Please enter <u>SYMPTOM 2 (S2)</u> here</p> <hr/>	<p>Please enter <u>SYMPTOM 3 (S3)</u> here</p> <hr/>
<p>When did you first start to experience S1?</p> <hr/>	<p>When did you first start to experience S2?</p> <hr/>	<p>When did you first start to experience S3?</p> <hr/>
<p>Please circle the current level of severity of S1</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>MILD MODERATE SEVERE</p>	<p>Please circle the current level of severity of S2</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>MILD MODERATE SEVERE</p>	<p>Please circle the current level of severity of S3</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>MILD MODERATE SEVERE</p>
<p>How often on average do you experience S1?</p> <p>Please circle one.</p> <p>Once or twice A few times Fairly often</p> <p>1 2 3</p> <p>Very often Every day/almost every day</p> <p>4 5</p>	<p>How often on average do you experience S2?</p> <p>Please circle one.</p> <p>Once or twice A few times Fairly often</p> <p>1 2 3</p> <p>Very often Every day/almost every day</p> <p>4 5</p>	<p>How often on average do you experience S3?</p> <p>Please circle one.</p> <p>Once or twice A few times Fairly often</p> <p>1 2 3</p> <p>Very often Every day/almost every day</p> <p>4 5</p>
<p>How long on average does S1 last?</p> <p>Please circle one.</p> <p>A few minutes Up to one hour Several hours</p> <p>1 2 3</p> <p>One or two days More than 2 days</p> <p>4 5</p>	<p>How long on average does S2 last?</p> <p>Please circle one.</p> <p>A few minutes Up to one hour Several hours</p> <p>1 2 3</p> <p>One or two days More than 2 days</p> <p>4 5</p>	<p>How long on average does S3 last?</p> <p>Please circle one.</p> <p>A few minutes Up to one hour Several hours</p> <p>1 2 3</p> <p>One or two days More than 2 days</p> <p>4 5</p>

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

- | | | | |
|-----------------------------|-----------------------------|-----------------------|--------------------------|
| L M S sinus problems | L M S nose bleeds | L M S dry mouth | L M S thirst |
| L M S difficulty swallowing | L M S sore throat/mouth | L M S headaches | L M S thrush/leukoplakia |
| L M S dental/gum | 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) _____ | | |

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

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 jaundice
 L M S other (specify) _____

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 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) _____

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

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**

WESTERN MEDICATIONS

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

Medication/Supplement/Herb	Used to Treat	Side-Effects Experienced
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____

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