American Specialty Health Plans of California, Inc. (ASH Plans)
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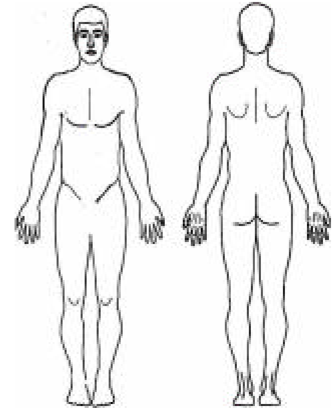
INITIAL HEALTH STATUS

(Chiropractic) Fax: 877/427-4777

Patient Name ________________________________ Birthdate __________ Sex M / F Primary Language ____________________________
Address _______________________________________City ___________________________ State__________ Zip __________________
Cell # ( ) _______________Telephone ( ) ____________ Email ___________________________Referred by ______________________
Occupation_______________________________ Employer ____________________________________Work Phone __________________
Address____ City ______________________State _________Zip _________________
Subscriber Name ____
Health Plan: ____
Subscriber ID #___________________Group #_________________________ Spouse Name ______________________________
Spouse Employer ______________________________ City _________________ State _______ Zip ________________________
Primary Care Physician (PCP)Name _________________________________ PCP Phone ______________________________

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS →



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

❑ Headache ❑ Neck Pain ❑ Mid-back Pain ❑ Low Back Pain

❑ Other ____

Is this? ❑ Work Related ❑ Auto Related ❑ N/A

Date Problem Began: ______________________________________

How Problem Began: ______________________________________

Current Complaint (How you feel today):
0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Intermittent) ❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?)

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ❑ **No** ❑ **Yes**

Date(s) taken: ________________________________ **What areas were taken?** __________________________

Please check all of the following that apply to you:

- ❑ Recent Fever
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Stroke (date): _________________________
- ❑ Corticosteroid Use (cortisone, prednisone, etc.)
- ❑ Taking Birth Control Pills
- ❑ Dizziness/Fainting
- ❑ Numbness in Groin/Buttocks
- ❑ Cancer/Tumor (explain): _________________
- ❑ Osteoporosis
- ❑ Epilepsy/Seizures
- ❑ Prostate Problems
- ❑ Menstrual Problems
- ❑ Urinary Problems
- ❑ Currently Pregnant, # weeks: _____________
- ❑ Abnormal Weight: ❑ Gain ❑ Loss
- ❑ Marked Morning Pain/Stiffness
- ❑ Pain Unrelieved by Position or Rest
- ❑ Pain at Night
- ❑ Visual Disturbances
- ❑ Surgeries: ____________________________
- ❑ Medications: __________________________
- ❑ Other Health Problems (explain): ___________

Family History: ❑ Cancer ❑ Diabetes ❑ High Blood Pressure ❑ Heart Problems/Stroke ❑ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature: ___________________________________ Date: _________________________