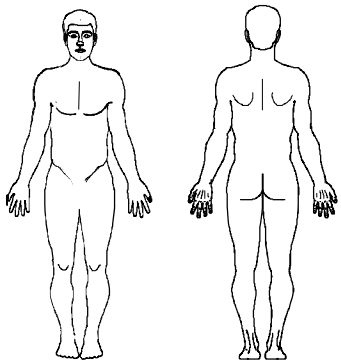
American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
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 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?
(Occasional) ☐ 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

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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:

☐ Alcohol/Drug Dependence
☐ 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
☐ Other Health Problems (Explain)_____

☐ 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_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

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 may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

Chiropractic Case History/Patient Information

Date:_____

Name:_____ Social Security #_____

E-mail Address:_____ Cell Phone:_____ Marital Status:_____

Primary Insured Name: _____ Primary Insured's DOB: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How were you referred to our office?_____

CASE HISTORY:

Chief complaint — Purpose of this appointment:_____

What does this prevent you from doing or enjoying?_____

If this is a recurrence, when was the first time you noticed this problem?_____

How did it originally occur?_____

Has it become worse recently? □ Yes □ No □ Same □ Better □ Gradually Worse

If yes, when and how? _____

How frequent is the condition? □Constant □Daily □Intermittent □Night Only

How long does it last? □ All Day □ A Few Hours □ A Few Minutes

Are there any other conditions or symptoms that may be related to your major symptom? □ Yes □ No

If yes, describe: _____

Are there other unrelated health problems? □ Yes □ No

If yes, describe _____

Describe the pain: □ Sharp □ Dull □ Numbness □ Tingling □Aching □Burning □Stabbing

□ Other: _____

Is there anything you can do to relieve the problem? □ Yes □ No If yes, describe _____

If no, what have you tried to do that has not helped? _____

What makes the problem worse? □ Standing □ Sitting □ Lying □ Bending □ Lifting □ Twisting

□ Other _____

Have you ever had the same or a similar condition? □ Yes □ No If yes, when and describe:_____

_____

Do you have a history of stroke or hypertension? □ Yes □ No

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? (include dates):

_____

_____

Have you been treated for any health condition by a physician in the last year? □ Yes □ No

If yes, describe:_____

What medications, drugs or supplements are you currently taking?_____

_____

Women: Are you pregnant or is there any possibility that you may be pregnant? □ Yes □ No □ Uncertain

PATIENT NAME _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

Headaches		Chest Pains/Tightness		Loss of Memory	
Frequency		Muscle Spasms		Ears Ring	
Neck Pain		Shoulder/Neck/Arm Pain		Broken Bones	
Back Pain		Fever		Circulation Problems	
Fainting/Dizziness		Numbness in Fingers		Rheumatoid Arthritis	
Stiff Neck		Sinus Problems		Excessive Bleeding	
Sleeping Problems		Numbness in Toes		Low Blood Pressure	
Loss of Balance		Indigestion Problems		Pacemaker	
Loss of Taste		Difficulty Urinating		Heart Disease	
Loss of Smell		Joint Pain/Swelling		Eating Disorder	
Unusual Bowel Patterns		Weakness in Extremities		HIV Positive	
Nervousness		Breathing Problems		Gall Bladder Problems	
Tension		Weight Loss/Gain		Ulcers	
Hands/Feet Cold		Fatigue		Stroke	
Irritability		Depression			
Osteoarthritis		Lights Bother Eyes			

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise
_____ Moderate Exercise
_____ Alcohol Use
_____ Drug Use
_____ Tobacco Use
_____ Caffeine
_____ High Stress Activity

_____ Family Pressures
_____ Financial Pressures
_____ Other Mental Stresses
_____ Other (specify)_____
_____
_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate which immediate family members (mother, father, siblings, children) have any current health problems.

_____ Arthritis	_____ Emphysema	_____ Migraine
_____ Asthma-Hay Fever	_____ Epilepsy	_____ Nervousness
_____ Back Trouble	_____ Headaches	_____ Neuritis
_____ Bursitis	_____ Heart Trouble	_____ Neuralgia
_____ Cancer	_____ High Blood Pressure	_____ Pinched Nerve
_____ Constipation	_____ Insomnia	_____ Scoliosis
_____ Diabetes	_____ Kidney Trouble	_____ Sinus Trouble
_____ Disc Problem	_____ Liver Trouble	_____ Stomach Trouble

I certify the information provided is accurate to the best of my knowledge.

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____