American Specialty Health Networks (ASH Networks)
P.O. Box 509001, San Diego, CA 92150-9001

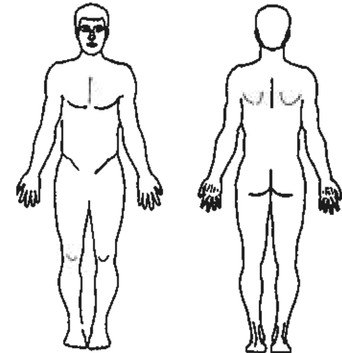
INITIAL HEALTH STATUS
(Chiropractic) Fax: 877.304.2746

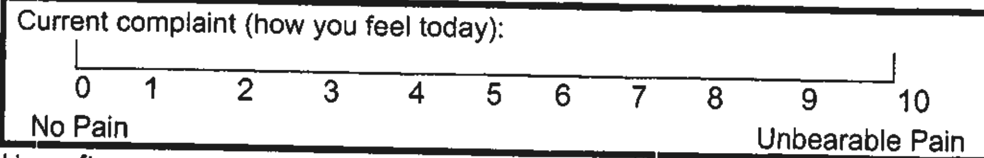
Patient Name: ______________________ Birthdate: ______________ Sex: M / F
Address ______________________ City ______________
State ______ Zip ________ Telephone (____) __________ Social Security #: __________
Occupation: ______________ Employer: ______________ Work Phone. __________
Address: ______________ 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?
(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
☐ 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______________
☐ 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 or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: ______________________ **Date:** ______________

SUMMARY

1. What is your major symptom? ______________________________
2. What does this prevent you from doing or enjoying? ______________________________
3. 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? ______________________________
4. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___
   How long does it last? All Day ______ Few Hours ______ Minutes ______
5. 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 ______
   ____
6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___
   Burning ___ Stabbing ___ Other ______________________________
7. 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? ______
   ____
8. What makes the problem worse? Standing ___. Sitting ___ Lying ___ Bending ___
   Lifting ___ Twisting ___ Other ______________________________
9. List any major accidents you have had other than those that might be mentioned above: ______
   ____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes ___ No ___ Uncertain ___
11. Remarks: ______________________________
    ____
    ____

NO SYMPTOMS ______________________________ EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Doctor's Signature ______________________________ Date ______________

Do you have any allergies of any kind? Yes No

If yes, describe:______________________________

Please list any other health problems you have, no matter how insignificant they may be:______________________________

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?______________
Do you use any tobacco products?_____ Do you smoke?____ If so, packs per day: ________
Do you take vitamin supplements?_______ If so, please list:______________
Do you consume caffeine?____ If so, how much per day:______________
Do you exercise?__________ If yes, what is the frequency and type of exercise?__________
What are your hobbies?______________________________
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending______working at a computer_______

FAMILY HISTORY:

Parents:

Father: living___ deceased____ Current age if still living:______ Cause of death and age at death if deceased:__________________ (check one)

Mother: living___ deceased____ Current age if still living:______ Cause of death and age at death if deceased:__________________ (check one)

Check if applicable to you: _________ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list:______________________________

FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis____
Diabetes ____
Stroke ____
Arthritis_____
Other ______________________________
Cancer____
Asthma____
Kidney Disease____
Liver Disease ____
Mental Illness____
Heart Disease ____
Lung Disease____

Please check any and all insurance coverage that may be applicable in this case:
Major Medical Worker's Compensation Medicaid Medicare Auto Accident
Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company:______________________________
Name of Secondary Insurance Company (if any):______________________________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:______________________________ Date:__________

Guardian's Signature Authorizing Care:______________________________ Date:__________

Name ________________________________ **Date** ______________

Social History

[ ] Single
[ ] Married
[ ] Divorced
Number of Children: ______

[ ] Smoker
[ ] Non-Smoker
[ ] Drinks Alcohol
[ ] Does not drink Alcohol
[ ] Takes Drugs
[ ] Does not take Drugs

List your Hobbies & Exercise Activities

____

____

____

Occupational History

Your Employer ______________________

Job Title ______________________

Are your Job Duties Physically demanding for you? [ ] Yes [ ] No
Have you had any disability time? [ ] Yes [ ] No
If you are currently working which are you performing?
[ ] Regular Duties
[ ] Limited – Light Duties

What is your current job satisfaction:
[ ] Very Satisfied
[ ] Satisfied
[ ] Dissatisfied
[ ] Very Dissatisfied

Your highest level of education attained?_________

Medical History

I have seen the following physician/practitioners for this condition:
Chiropractor (Name): ______________________
Massage Therapist: ______________________
Neurologist: ______________________
Orthopedist: ______________________
Physical Therapist: ______________________
Physician: ______________________
Psychiatrist/Psychologist: ______________________
Other: ______________________

List the treatments you have had for this condition.
[ ] Ice
[ ] Heat/Ultrasound
[ ] Electrical Stimulation
[ ] Exercises
[ ] Gravity Inversion – Traction
[ ] Bed Rest
[ ] Chiropractic
[ ] Osteopathy
[ ] Injections
[ ] Acupuncture
[ ] Naturopathy
[ ] Massage

List previous back, neck and musculoskeletal problems:

____

____

____

Do you feel you are troubled with:
[ ] Anxiety
[ ] depression
[ ] irritability

Current medications I am taking:

____

____

____

____

Past Surgeries:

____

____

____

____

Past Hospitalizations:

____

____

____

____

____

PATIENT INJURY/MEDICAL HISTORY FORM

Name ______________________________ **Date** ______________________

List the types of Diagnostic Testing that has been for this condition:

[ ] X-rays
[ ] CT Scan
[ ] Myelogram
[ ] MRI
[ ] Discogram
[ ] Bone Scan
[ ] EMG

Females – Mark if have the following:

[ ] Vaginal bleeding other than period
[ ] Pap smear within last two years
[ ] Painful menstrual periods
[ ] Back pain with menstrual periods
[ ] Other menstrual problems

Mark if you have had any of the following symptoms in the past 5 years:

[ ] Unexplained fevers
[ ] Night sweats
[ ] Weight loss of 10 lbs or more
[ ] Loss of appetite
[ ] Excessive fatigue
[ ] Problems with depression
[ ] Difficulty sleeping
[ ] Unusual stress at work
[ ] Unusual stress at home
[ ] Easy bruising
[ ] Excessive bleeding
[ ] Lumps in neck, armpit or groin
[ ] Chest pain or tightness
[ ] Persistent or unusual cough
[ ] Trouble breathing with exercise
[ ] Trouble breathing lying flat
[ ] Coughing up blood
[ ] Swollen ankles
[ ] Stomach pain
[ ] Change in bowel habits
[ ] Persistent diarrhea
[ ] Excessive constipation
[ ] Dark black stools
[ ] Blood in stools
[ ] Pain-burning when urinating
[ ] Difficulty urinating – start / stop
[ ] Blood in urine
[ ] Need to urinate more at night
[ ] Morning stiffness
[ ] Persistent eye redness
[ ] Muscle tenderness
[ ] Dry eyes or mouth
[ ] Skin rashes
[ ] Joint pain or swelling