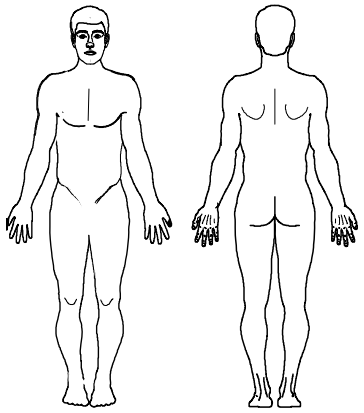
American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

Patient Name _____ Birthdate _____ Sex M / F
Address _____ City _____
State _____ Zip _____ Telephone (____) _____ 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?
(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 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** _____