American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
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INITIAL HEALTH STATUS Chiropractic

Patient Name			Birthdat	e	Sex: M / F	
StateZip	Phone ()	Patient	Primary Language		
Occupation	Emplo	yer		Work Phone_		
Address		City		State	Zip	
Subscriber Name		ŀ	Health Plan			
Subscriber ID #	Gr	oup #	Sp	ouse Name		
Spouse Employer_		City		State	Zip	
Primary Care Phys	ician Name			PCP Phone		
Headache Other Is this? Work Work Date Problem Beg How Problem Beg Current complaint 0 1 No Pain How often are your (Occasional) 0 0 In the past week, how No interference 0 In general would	t (how you feel today): 2 3 4 5 r symptoms present? - 25%	Pain Low Bac Pain N/ P	y activities (e.g.,	work, social activities,	- 100% (Constant) or household chores?	
☐ 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?						
Alcohol/Drug Recent Feve Diabetes High Blood I Stroke (Date Corticostero Taking Birth Dizziness/Fa	Pressure e) id Use (Cortisone, Predni Control Pills	sone, etc.)	Menstru Urinary Currently Abnorma Marked Pain Un Pain at N Visual D	Problems al Problems Problems y Pregnant, # Weeks al Weight ☐ Gain ☐ Morning Pain/Stiffnes relieved by Position of Night isturbances	Loss ss or Rest	
Family History: I certify to the best not accurate, or if liable for all charge changes in my heart	zures n Problems (Explain) Cancer Heart Problems/Strok of my knowledge, the ab I am not eligible to recei ges for services rendere alth condition or health pla an if my condition needs	ove information is ve a health care d and I agree to an coverage in the	etes matoid Arthritis s complete and benefit throug o notify this p ne future. I und	I accurate. If the healed this practitioner, I ractitioner immediate erstand that my chiro	Pressure Ith plan information is understand that I amely whenever I have opractor may need to	
Patient Signature_			Date			