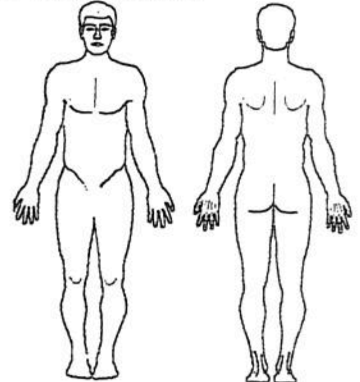
American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002

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.



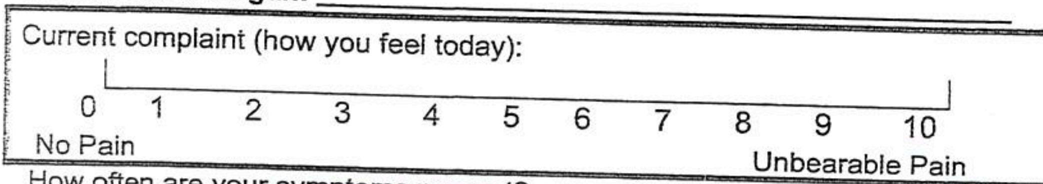
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain
☐ Other ______________

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

Date Problem Began: ______________

How Problem Began: ______________

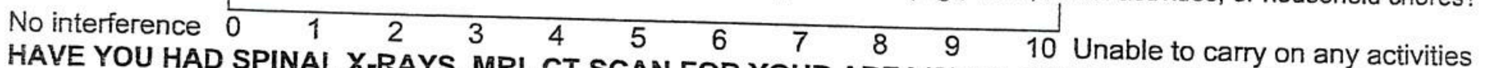


Current complaint (how you feel today):

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** ______________

Patient Information Continued

Cell Phone ________________________________

Email ________________________________

___Single ___Married ___Divorced ___Widowed

Social Security Number________________________

In Case of Emergency, Contact:
Name________________________________

Relationship________________________________

Phone Number________________________________

How did you hear about us? Who may we thank for your referral?

____
____
____

Other Injury Information Or Current Complaints

Is there anything else you would like us to know about your current condition or about yourself?

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____
____
____
____

How is the condition you are seeing us for affecting your life?

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____

What have you tried regarding this issue before you came to our office?

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____
____
____
____

Do you work out? If so, how often and what do you do?

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____
____
____
____

Does anyone in your family have a similar condition?________________________________
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