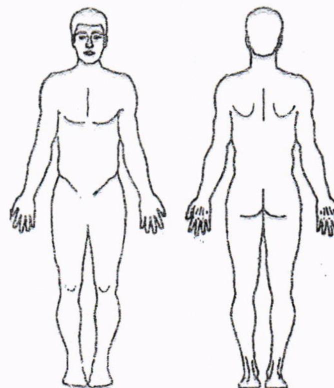
American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002

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.



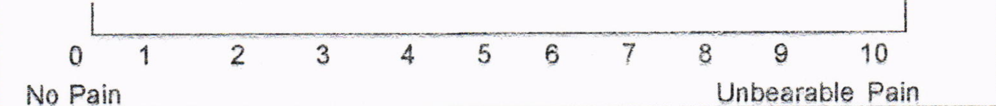
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ 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
☐ 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 ______________

Height ______________
Weight ______________
Blood Pressure ______________
Pulse ______________
Respiration ______________

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** ______________

Email Address: ______________________