American Specialty Health (ASH) P.O. Box 509001, San Diego, CA 92150-9001 Fax: 877.248.2746

**INITIAL HEALTH STATUS** 

Acupuncture
For questions, please call ASH at 800.972.4226

Last	Patient Name	Birthdate_		Primary Lang	juage	Sex M / F
Employer			State	7in	Primary Phone	
Subscriber Name						
Primary Health Plan						
Are you under the care of a physician?   No   Yes, for what conditions?   PCP Phone #						
Are you under the care of a physician? No Yes, for what conditions? Please describe your current health problem(s)	2 <sup>nd</sup> Health PlanF	Primary Care Physician (	PCP)		PCP Phone #	
Please describe your current health problem(s)	Are you under the care of a phy	vsician? □ No □ Yes.	for what co	nditions?		(Required)
Is this work related? Y / N   What treatment have you received for the above condition(s)?   Surgery   Medications   Physical Therapy   Injections   Chiropractic   Massage   Other     Please describe your progress:   Worse   No Change   25% Better   50% Better   75% Better or     Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other     No Pain	Please describe your current h	ealth problem(s)				
Injections   Chiropractic   Massage   Other   Please describe your progress:   Worse   No Change   25% Better   50% Better   75% Better or	How and When it began		/ \		_ Is this work re	lated? Y / N
Please describe your progress:   Worse   No Change   25% Better   50% Better   75% Better or    Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other    No Pain   0   1   2   3   4   5   6   7   8   9   10   Unbearable Pain    In the past week, how much has your pain interfered with your daily activities?  No Interference   0   1   2   3   4   5   6   7   8   9   10   Unbearable Pain    In the past week, how much has your pain interfered with your daily activities?  No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10   Unable to carry on any activities    No Interference   0   1   2   3   4   5   6   7   8   9   10	What treatment have you receive	d for the above condition	n(s)? ∐ Sur	gery   Med	ications	sical Therapy
Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other	☐ Injections ☐ Chiropractic ☐ Please describe vour progress: □	Massage ☐ Other ¬ Worse	☐ 25% Bett	er	 etter □ 75% Be <sup>t</sup>	tter or
Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other  No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain In the past week, how much has your pain interfered with your daily activities?  No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities  How often are your symptoms present?						
In the past week, how much has your pain interfered with your daily activities?  No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities  How often are your symptoms present?						
No Interference	<b>No Pain</b> 0 1 2	3 4 5	6 7	8 9	10	rable Pain
How often are your symptoms present?   Constantly   Frequently   Good   Good   Fair   Poor      Please check all of the following that apply to you and list any medication(s) you are taking:   Alcohol/Drug Dependence   Frequent Urination   Stroke   Tobacco Use - Type   Frequenty   Thyroid Disease   Thyroid Disease   Angina   Heart Attack   Frequency   Day   Thyroid Disease   Arthritis/   High Blood Pressure   Arthritis/   Hospitalizations/Surgical   Arthritical Joints   Procedures   Medications   Medications   Medications   Medications   Medications   Medications   Thyroid Disease   If a family member has had any of the following, please mark the appropriate box and explain the relationship:   Cancer/Tumor   Osteoporosis   Diabetes   Palpitation/Arrhythmia   Heart Disease   Heart Disease	-	•	-			
Please check all of the following that apply to you and list any medication(s) you are taking:    Alcohol/Drug Dependence	No Interference <u>0 1 2</u>	3 4 5 6 7	8 9	10 Unable	to carry on any	activities
Alcohol/Drug Dependence	How often are your symptoms properties of the pr	esent?	☐ Frequentl☐ Very Goo	y 🔲 Interm d 🔲 Good	ittently 🔲 C	
Alcohol/Drug Dependence		41 4 1 4				
I certify that the above information is complete and accurate to the best of my knowledge. 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. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my provider of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be comanaged. Therefore, I give authorization to my provider of acupuncture services to contact my medical doctor if necessary.	☐ Alcohol/Drug Dependence ☐ Abnormal Menstruation ☐ Allergies ☐ Angina ☐ Arthritis/ Rheumatoid Arthritis ☐ Artificial Joints ☐ Asthma ☐ Blood Disorder ☐ Breast Lumps ☐ Cancer/Tumor ☐ Convulsions/Seizures ☐ Diabetes ☐ Diarrhea/Constipation ☐ Excessive Thirst ☐ Fainting or Dizziness ☐ Fatigue	Frequent Urination Headache Heart Attack Heartburn or Indige High Blood Pressur Hospitalizations/Sur Procedures Kidney Disease Liver Problems Osteoporosis Pacemaker Palpitation/Arrhythr Peptic Ulcer Pregnant, # Weeks Prostate Problems Weight Gain/Loss	estion re rgical mia	Stroke Tobacc Frequer Thyroid Other  Medica  If a family r following, p box and ex Cancer Heart D Hyperte Lupus	o Use - Type ncy Disease  Itions member has had blease mark the aplain the relation bisease ension	_/Day any of the appropriate aship:
Patient signature Date	I certify that the above information is not accurate, or independent of the condition of th	f I am not eligible to re I charges for services. lition or health plan cover Primary Care Physicial	eceive a hea I agree to no erage. I und n or treating p	Ith care bend tify this providerstand that in only sician if m	efit through this der immediately my provider of a ly condition need	provider, I whenever I cupuncture ds to be co-
	Patient signature				Date	