

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M / F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver Lic. #: \_\_\_\_\_  
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.

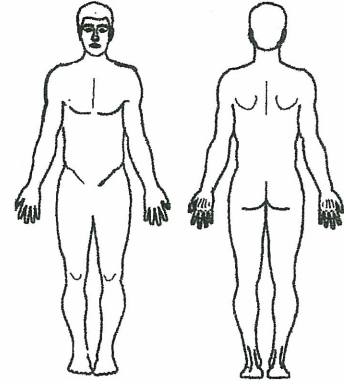
**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

- Headache     Neck Pain     Mid-back Pain     Low Back Pain  
 Other \_\_\_\_\_

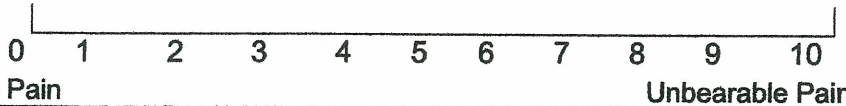
Is this?     Work Related     Auto Related     N/A

Date Problem Began: \_\_\_\_\_

How Problem Began: \_\_\_\_\_



Current complaint (how you feel today):



How often are your symptoms present?     0 – 25%     26 – 50%     51 – 75%     76 – 100%

Can you perform your daily activities?     Yes     No (Describe any current activity limitations) \_\_\_\_\_

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN?     No     Yes Date(s) taken: \_\_\_\_\_

**WHAT AREAS WERE TAKEN?**

Please check all of the following that apply to you:     None Apply

- | No                       | Yes                      | Condition                   | No                       | Yes                      | Condition   |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever                | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination  |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                    | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                    | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use          | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures   |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills         | <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances   |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         | <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____         | <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting          | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks  | <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention           | <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm             | <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor                |                          |                          | _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                |                          |                          | _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma               |                          |                          | _____   |

Family History:     Cancer     Diabetes     High Blood Pressure     Cardiovascular Problems/Stroke

I certify that 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: \_\_\_\_\_