Patient Name:	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
Address:		
Telephone: Social Security #: Driver Lic. #:  Occupation: Employer: Work Phone: Address: State: Zip: State: Zip: Subscriber Name: Spouse Name: Spouse Employer: City: State: Zip: 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: Unbearable Pain  How Problem Began: On 1 2 3 4 5 6 7 8 9 10  No Pain Unbearable Pain  How often are your symptoms present? On 25% Occurrent activity limitations)  HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Pess Date(s) taken: WHAT AREAS WERE TAKEN?  Please check all of the following that apply to you: None Apply No Yes Condition Prostate Problems Recent Fever Pistory of Recent Infection Recent Fever Pistory of Recent Infection Recent Fever Pistory of Recent Infection Pregnancy, # of births Diabetes Abnormal Weight Osaria Diszbress/Fainting High Blood Pressure Pistory of Low/Mid Back Pain History of Steoporosis Surgerles/Medications: Surgerles/Medications: Surgerles/Medications: Surgerles/Medications:	Address: City:	State: Zip:
Coccupation:   Employer:   City:   State:   Zip:   Zip:   Subscriber Name:   Health Plan:   Spouse Employer:   City:   State:   Zip:   State:   Zip:   Spouse Employer:   City:   State:   Zip:   Zip:   Spouse Employer:   City:   State:   Zip:   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   Down Began:   Mork Related   Auto Related   N/A   Date Problem Began:   Down Be	Telephone: Social Security #:	Driver Lic. #:
Address:		
Subscriber Name:	Address: City:	State: Zip:
Subscriber ID #	Subscriber Name: Health F	Plan:
Spouse Employer:	Subscriber ID #: Group #:	Spouse Name:
Primary Care Physician Name:		
Headache   Neck Pain   Mid-back Pain   Low Back Pain     Other   Stroke (date)   Other     History of Recent Infection   Recent Fever   History of Neck Pain     History of Neck Pain   Mid-back Pain   Low Back Pain     Other   Stroke (date)   Dizziness/Fainting   Dizziness/Fainting     Numbness in Groin/Buttocks   University   Other     History of Alcohol Use   History of Tobacco Use     Dizziness/Fainting   Dizziness/Fainting   Dizziness/Fainting     Numbness in Groin/Buttocks   University     History of Tobacco Use   University     Dizziness/Fainting   Dizziness/Medications:     Cancer/Tumor   Osteoporosis     Cancer/Tumor   Osteoporosis     Cancer/Tumor   Osteoporosis     Contend   Dizziness/Fainting   Dizziness/Medications:     Cancer/Tumor   Osteoporosis     Contend   Dizziness/Medications:     Cancer/Tumor   Osteoporosis     Contend   Dizziness/Medications:     Cancer/Tumor   Osteoporosis     Contend   Dizziness/Medications:     Contend   Dizziness/Medications:     Cancer/Tumor   Osteoporosis     Contend   Dizziness/Medications:     Contend   Dizziness/Medications:     Cancer/Tumor   Osteoporosis     Current Cancer/Tumor   Osteoporosis   Osteoporosis     Current Cancer/Tumor   Osteoporosis     Current Cancer/Tumor   Osteoporosis     Current Cancer/Tumor   Osteopo	Primary Care Physician Name:	PCP Phone:
Headache	MARK AN X ON THE PICTURE WHERE	YOU HAVE PAIN OR OTHER SYMPTOMS.
Other Is this?   Work Related   Auto Related   N/A   Date Problem Began:   How Problem Began:   How Problem Began:   Unbearable Pain   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   Prostate Problems	DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:	
Is this?   Work Related	Headache Neck Pain Mid-back Pain Low Back F	ain
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  How often are your symptoms present? Can you perform your daily activities? Can you perform your daily activities?  WHAT AREAS WERE TAKEN? Please check all of the following that apply to you: No Yes Condition  History of Recent Infection Recent Fever HIV/AIDS Diabetes Diabete	Other	(sla) (NU)
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Current complaint (how you feel today):  0 1 2 3 4 5 6 7 8 9 10  No Pain  How often are your symptoms present? Can you perform your daily activities?  HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Describe any current activity limitations)  HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Pes Date(s) taken:  WHAT AREAS WERE TAKEN?  Please check all of the following that apply to you: No Yes Condition History of Recent Infection Recent Fever History of Recent Infection Recent Fever HIVIAIDS Diabetes Corticosteroid Use Birth Control Pills High Blood Pressure History of Low/Mid Back Pain History of Nock Pain History of Neck Pain History of Tobacco Use Aortic Aneurysm Cancer/Tumor Streeporosis	Date Problem Began:	
Current complaint (how you feel today):    O 1 2 3 4 5 6 7 8 9 10   Unbearable Pain	How Problem Began:	Man I last of the last
No Pain    No Pain		
No Pain	Current complaint (how you feel today):	)-/-{ ) //-{
No Pain	0 4 0 0 4 5 6 7 0 0 4	
How often are your symptoms present?		1111
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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  History of Recent Infection  Recent Fever  HIV/AIDS  Diabetes  Corticosteroid Use  Birth Control Pills  High Blood Pressure  High Blood Pressure  Stroke (date)  Dizziness/Fainting  Numbness in Groin/Buttocks  History of Alcohol Use  Urinary Retention  Aortic Aneurysm  Cancer/Tumor  Osteoporosis	Can you perform your daily activities?	1%
WHAT AREAS WERE TAKEN?  Please check all of the following that apply to you:  No Yes Condition  History of Recent Infection  Recent Fever  HIV/AIDS  Diabetes  Corticosteroid Use Birth Control Pills  High Blood Pressure  High Blood Pressure  Stroke (date)  Dizziness/Fainting  No Yes Condition  Prostate Problems  Frequent Urination  Pregnancy, # of births  Abnormal Weight Gain Loss  Epilepsy/Seizures  Visual Disturbances  History of Low/Mid Back Pain  History of Neck Pain  Arthritis  Numbness in Groin/Buttocks  History of Alcohol Use  Urinary Retention  Aortic Aneurysm  Cancer/Tumor  Osteoporosis	Carryou perform your daily activities:	any content activity limitations)
WHAT AREAS WERE TAKEN?  Please check all of the following that apply to you:  No Yes Condition  History of Recent Infection  Recent Fever  HIV/AIDS  Diabetes  Corticosteroid Use Birth Control Pills  High Blood Pressure  High Blood Pressure  Stroke (date)  Dizziness/Fainting  No Yes Condition  Prostate Problems  Frequent Urination  Pregnancy, # of births  Abnormal Weight Gain Loss  Epilepsy/Seizures  Visual Disturbances  History of Low/Mid Back Pain  History of Neck Pain  Arthritis  Numbness in Groin/Buttocks  History of Alcohol Use  Urinary Retention  Aortic Aneurysm  Cancer/Tumor  Osteoporosis	HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Ye	es Date(s) taken:
No Yes Condition  History of Recent Infection  Recent Fever  HIV/AIDS  Diabetes  Corticosteroid Use Birth Control Pills  High Blood Pressure  Stroke (date)  Dizziness/Fainting  No Yes Condition  Prostate Problems  Frequent Urination  Pregnancy, # of births  Abnormal Weight Gain Loss  Epilepsy/Seizures  Visual Disturbances  History of Low/Mid Back Pain  History of Neck Pain  Arthritis  Numbness in Groin/Buttocks  History of Alcohol Use  Urinary Retention  Aortic Aneurysm  Cancer/Tumor  Osteoporosis	WHAT AREAS WERE TAKEN?	
History of Recent Infection   Prostate Problems   Recent Fever   Frequent Urination   Pregnancy, # of births   Diabetes   Abnormal Weight   Gain   Loss   Epilepsy/Seizures   Epilepsy/Seizures   High Blood Pressure   History of Low/Mid Back Pain   Stroke (date)   History of Neck Pain   Dizziness/Fainting   Arthritis   Numbness in Groin/Buttocks   History of Alcohol Use   Urinary Retention   History of Tobacco Use   Surgeries/Medications:   Cancer/Tumor   Osteoporosis		
☐ Recent Fever       ☐ Frequent Urination         ☐ HIV/AIDS       ☐ Pregnancy, # of births         ☐ Diabetes       ☐ Abnormal Weight ☐ Gain ☐ Loss         ☐ Corticosteroid Use       ☐ Epilepsy/Seizures         ☐ Birth Control Pills       ☐ Visual Disturbances         ☐ High Blood Pressure       ☐ History of Low/Mid Back Pain         ☐ Stroke (date)       ☐ History of Neck Pain         ☐ Dizziness/Fainting       ☐ Arthritis         ☐ Numbness in Groin/Buttocks       ☐ History of Alcohol Use         ☐ Urinary Retention       ☐ History of Tobacco Use         ☐ Aortic Aneurysm       ☐ Surgeries/Medications:         ☐ Cancer/Tumor       ☐ Osteoporosis		
HIV/AIDS		
□ Diabetes       □ Abnormal Weight □ Gain □ Loss         □ Corticosteroid Use       □ Epilepsy/Seizures         □ Birth Control Pills       □ Visual Disturbances         □ High Blood Pressure       □ History of Low/Mid Back Pain         □ Stroke (date)       □ History of Neck Pain         □ Dizziness/Fainting       □ Arthritis         □ Numbness in Groin/Buttocks       □ History of Alcohol Use         □ Urinary Retention       □ History of Tobacco Use         □ Aortic Aneurysm       □ Surgeries/Medications:         □ Cancer/Tumor       □ Osteoporosis		
☐ Corticosteroid Use       ☐ Epilepsy/Seizures         ☐ Birth Control Pills       ☐ Visual Disturbances         ☐ High Blood Pressure       ☐ History of Low/Mid Back Pain         ☐ Stroke (date)       ☐ History of Neck Pain         ☐ Dizziness/Fainting       ☐ Arthritis         ☐ Numbness in Groin/Buttocks       ☐ History of Alcohol Use         ☐ Urinary Retention       ☐ History of Tobacco Use         ☐ Aortic Aneurysm       ☐ Surgeries/Medications:         ☐ Cancer/Tumor       ☐ Osteoporosis		
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☐ Dizziness/Fainting       ☐ Arthritis         ☐ Numbness in Groin/Buttocks       ☐ History of Alcohol Use         ☐ Urinary Retention       ☐ History of Tobacco Use         ☐ Aortic Aneurysm       ☐ Surgeries/Medications:         ☐ Cancer/Tumor       ☐ Osteoporosis		
☐       Numbness in Groin/Buttocks       ☐       History of Alcohol Use         ☐       Urinary Retention       ☐       History of Tobacco Use         ☐       Aortic Aneurysm       ☐       Surgeries/Medications:         ☐       Cancer/Tumor       Osteoporosis		
Urinary Retention		
☐ Osteoporosis		
☐ Osteoporosis	Aortic Aneurysm	
	☐ Cancer/Tumor	
Recent Trauma		
Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke	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 a not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges it services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans meed to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to rechiropractor and/or ASH Plans to contact my physician, if necessary.	not eligible to receive a health care benefit through this provider, I services rendered and I agree to notify this doctor immediately when health plan coverage in the future. I understand that my chiropractor need to contact my physician if my condition needs to be co-mar	understand that I am liable for all charges for never I have changes in my health condition or or a clinical peer employed by ASH Plans may
Patient Signature: Date:	151.50 155	9: