INITIAL HEALTH STATUS DATE_____

Name _____ Email: _____
FIRST INITIAL LAST

Address _____ City _____ State _____ Zip _____

Telephone - Home _____ Work/Cell _____ Soc Sec. # _____

Drivers Lic. _____ Age _____ Birth Date _____ M / F Status- M / S / W / D No. of Children _____

Occupation _____ Employer _____ Years Employed _____

Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Employer _____

I have been queried regarding possessing insurance coverage and have declined to have my insurance billed ( ) Initial

Subscriber's Name _____ Health Plan _____ ID# _____ Group# _____

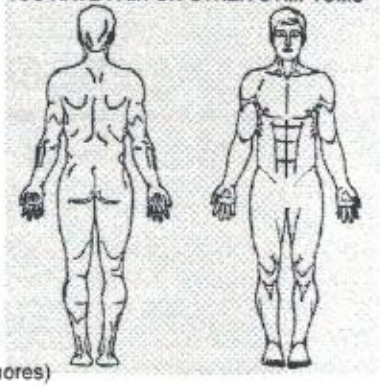
Primary Care Physician _____ Phone _____

Who may we thank for referring you to our office?

❑Friend:_____ ❑Insurance ❑Google ❑Yelp ❑Other:_____

Present Weight_____**Pounds** **Height**_____**Feet**_____**Inches**

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



DESCRIBE YOUR PROBLEM & 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%

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 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
- ❑ 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 _____
- ❑ Other Health Problems (explain)_____

Family History: ❑ Cancer ❑ Rheumatoid Arthritis ❑ Heart Problems / Stroke ❑ Diabetes ❑ High Blood Pressure

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's Signature: _____ **Date:** _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. (x)_____