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

INITIAL HEALTH STATUS

Acupuncture and Oriental Medicine

For questions, please call ASH at 800.972.4226

Patient Name_______________________________ Birthdate__________Primary Language_________________ Gender M / F
Last First

Address___________________________ City_________________ State_____ Zip_________ Primary Phone_____________

Employer___________________________ Occupation________________________ Other Phone_________________________

Subscriber Name___________________________ Subscriber ID #_________________Group #_________________________

Primary Health Plan____________________________________ Patient/Member ID #______________________________

2nd Health Plan_________________ Primary Care Physician (PCP)_____________________ PCP Phone #_______________
(Required) (Required)

Are you under the care of a physician? ☐ No ☐ Yes, for what conditions?___________________________

Please describe your current health problem(s)____

How and When it began____ 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 ☐ 0-25% Better ☐ 26-50% Better

☐ 51-75% Better ☐ 76-100% Better

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 **Unable to carry on any activities**

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

Describe your current health condition: ☐ Excellent ☐ Very 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
☐ 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
☐ Fever

☐ Frequent Urination
☐ Headache
☐ Heart Attack
☐ Heartburn or Indigestion
☐ High Blood Pressure
☐ Hospitalizations/Surgical Procedures__________________
____
☐ Kidney Disease
☐ Liver Problems
☐ Osteoporosis
☐ Pacemaker
☐ Palpitation/Arrhythmia
☐ Peptic Ulcer
☐ Pregnant, # Weeks____________
If pregnant, are you under a medical doctor's care? ☐Y ☐ N
☐ Prostate Problems

☐ Weight Gain/Loss
☐ Sinusitis
☐ Stroke
☐ Tobacco Use - Type______________
Frequency____________/Day
☐ Thyroid Disease
☐ Other__________________________
____
☐ **Medications**____________________
____

If a family member has had any of the following, please mark the appropriate box and explain the relationship:

☐ Cancer__________________________
☐ Heart Disease____________________
☐ Hypertension____________________
☐ Lupus__________________________
☐ Other__________________________

Comments____

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 practitioner, I understand that I am liable for all charges for services. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co- managed. Therefore, I give authorization to my practitioner of acupuncture services to contact my medical doctor if necessary.

Patient signature____ **Date**___________________