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

Patient Name__________________________ Birthdate____________Primary Language____________ Sex 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 ☐ 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 **Unable to carry on any activities**

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally
Describe your current health condition: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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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____________
☐ 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__________________________
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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 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 co-managed. Therefore, I give authorization to my provider of acupuncture services to contact my medical doctor if necessary.

Patient signature____ **Date**__________________