

INITIAL HEALTH STATUS

(Acupuncture)

For questions, please call ASH Plans 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

Please check all of the following that apply to you and list any medication(s) you are taking:

- | | | |
|---|---|--|
| <input type="checkbox"/> Alcohol/tobacco/drug dependence | <input type="checkbox"/> Fever | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Abnormal menstruation | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Headache | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arthritis/
rheumatoid arthritis | <input type="checkbox"/> Heartburn or indigestion | <input type="checkbox"/> Medications _____ |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hospitalizations/surgical procedures _____ | _____ |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Kidney disease | If a family member has had any of the following, please mark the appropriate box and explain the relationship:
<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Lupus _____
<input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Liver problems | |
| <input type="checkbox"/> Cancer/tumor | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Palpitation/arrhythmia | |
| <input type="checkbox"/> Diarrhea/constipation | <input type="checkbox"/> Peptic ulcer | |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Pregnant, # weeks _____ | |
| <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Prostate problems | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight gain/loss | |

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** _____