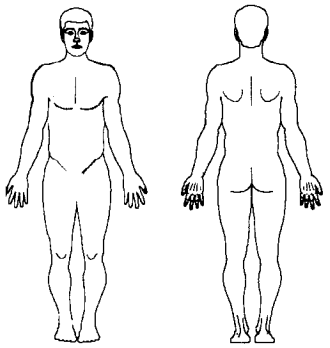
American Specialty Health Networks (ASH Networks)
P.O. Box 509001, San Diego, CA 92150-9001

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/304-2746

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
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: _____
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% (Constant)

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 on 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
☐ Other Health Problems (explain) _____
_____
_____

☐ 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: _____
_____
_____

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

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 Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____

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MEMBER PLAN REQUIREMENT ACKNOWLEDGMENT

(Chiropractic)

For questions, please call ASH Networks at 800/972-4226

_____
ASH Networks Contracted Chiropractor

_____
Address

Plan Requirement Acknowledgment:

I, _____ acknowledge that I have been advised that my health plan
(Name of Patient/Member/Guardian)

_____ through my employer,
(Name of Health Plan)

_____ requires a Primary Care Physician referral for
(Name of Employer Group)

coverage of chiropractic services.

I understand that my plan requires a Primary Care Physician referral before I access Covered Services and if I have not already obtained a referral as prescribed under the terms of my employer's Medical and Hospital Subscriber Agreement or Insurance Policy, I am liable for the charges listed below for services rendered. If the required referral condition is not met, I agree to pay in full for all services listed below within thirty (30) days of receiving a bill from the above chiropractor or health plan.

Date	Services Rendered	Charge
		$
		$
		$
		$
		$

_____ _____
Date Signature of Member (Or Subscriber)

_____ _____
Date Provider Signature

Note to Contracted Chiropractor's Office Personnel:

Please keep the original copy of the completed Member Plan Requirement Acknowledgment form in the member's file. If you need to submit this form to ASH Networks, please send it to ASH Networks at the address above. If you have any questions, call ASH Networks Provider Services at 800/972-4226.