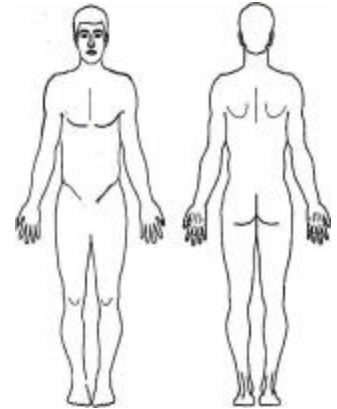


Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M / F Primary Language \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Cell # ( ) \_\_\_\_\_ Telephone ( ) \_\_\_\_\_ Email \_\_\_\_\_ Referred by \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Health Plan: \_\_\_\_\_  
 Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Spouse Name \_\_\_\_\_  
 Spouse Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Primary Care Physician (PCP) 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:** \_\_\_\_\_

<b>Current Complaint (How you feel today):</b>										
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:

- |   |   |
|---|---|
| <input type="checkbox"/> Recent Fever                                     | <input type="checkbox"/> Urinary Problems   |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Currently Pregnant, # weeks: _____   |
| <input type="checkbox"/> High Blood Pressure                              | <input type="checkbox"/> Abnormal Weight: <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Stroke (date): _____                             | <input type="checkbox"/> Marked Morning Pain/Stiffness  |
| <input type="checkbox"/> Corticosteroid Use (cortisone, prednisone, etc.) | <input type="checkbox"/> Pain Unrelieved by Position or Rest  |
| <input type="checkbox"/> Taking Birth Control Pills                       | <input type="checkbox"/> Pain at Night  |
| <input type="checkbox"/> Dizziness/Fainting                               | <input type="checkbox"/> Visual Disturbances  |
| <input type="checkbox"/> Numbness in Groin/Buttocks                       | <input type="checkbox"/> Surgeries: _____   |
| <input type="checkbox"/> Cancer/Tumor (explain): _____                    | _____   |
| _____   | <input type="checkbox"/> Medications: _____   |
| <input type="checkbox"/> Osteoporosis                                     | _____   |
| <input type="checkbox"/> Epilepsy/Seizures                                | <input type="checkbox"/> Other Health Problems (explain): _____                                       |
| <input type="checkbox"/> Prostate Problems                                | _____   |
| <input type="checkbox"/> Menstrual Problems                               | _____   |

Height \_\_\_\_\_ Weight \_\_\_\_\_

**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 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 Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_