

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M / F  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ Patient Primary Language \_\_\_\_\_  
 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.

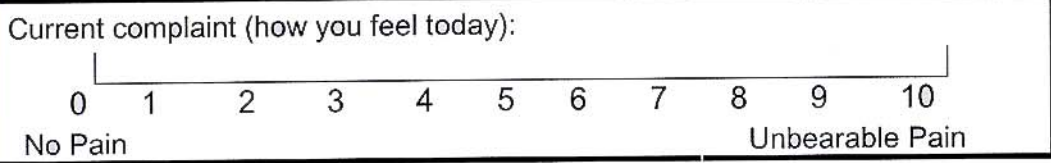
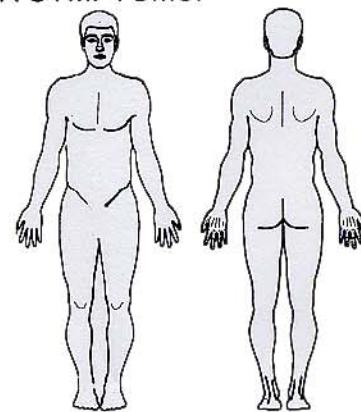
**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

- Headache    Neck Pain    Mid-back Pain    Low Back Pain  
 Other \_\_\_\_\_

Is this?    Work Related    Auto Related    N/A

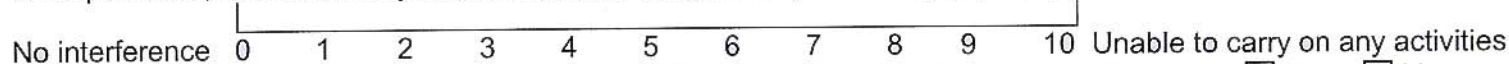
Date Problem Began: \_\_\_\_\_

How Problem Began: \_\_\_\_\_



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)?



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