

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

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcohol/Drug Dependence | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Abnormal Menstruation | <input type="checkbox"/> Headache | <input type="checkbox"/> Tobacco Use - Type _____
Frequency _____/Day |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heartburn or Indigestion | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arthritis/
Rheumatoid Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Medications _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hospitalizations/Surgical
Procedures _____ | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Liver Problems | 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"/> Osteoporosis | |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Palpitation/Arrhythmia | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Peptic Ulcer | |
| <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Pregnant, # Weeks _____ | |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Prostate Problems | |
| <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Weight Gain/Loss | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sinusitis | |
| <input type="checkbox"/> Fever | | |

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 practitioner, I understand that I am liable for all charges for services. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner 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 practitioner of acupuncture services to contact my medical doctor if necessary.

Patient signature _____ **Date** _____