

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M / F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 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: \_\_\_\_\_

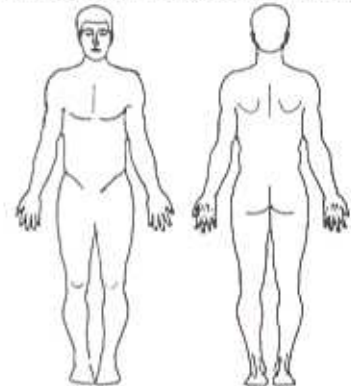
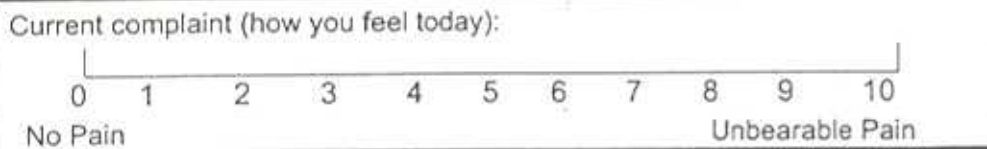
MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this?  Work Related  Auto Related  N/A

DATE PROBLEM BEGAN: \_\_\_\_\_



How often are your symptoms present?  0 - 25%  26 - 50%  51 - 75%  76 - 100%  
 Can you perform your daily activities?  Yes  No (Describe) \_\_\_\_\_

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN?  No  Yes Date(s) taken: \_\_\_\_\_

WHAT AREAS WERE TAKEN? \_\_\_\_\_

Please check all of the following that apply to you:  None Apply

- | No                       | Yes                      | Condition                   |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever                |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use          |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills         |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting          |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks  |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention           |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor                |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma               |

- | No                       | Yes                      | Condition   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures   |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____  |

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

Family History:  Cancer  Diabetes  High Blood Pressure  Cardiovascular Problems/Stroke

I certify that 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: \_\_\_\_\_

Referred by: \_\_\_\_\_