American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002 Fax: 877.248.2746

INITIAL HEALTH STATUS

Acupuncture

For questions, please call ASH Plans at 888.226.8879

Patient Name _____ Birthdate _____ Sex M / F
Last First

Address _____ City _____ State _____ Zip _____

Subscriber Name:_____ Subscriber ID #: _____Group #:_____

Phone # (Home):_____Work #: _____Employer _____Occupation_____

Primary Health Plan: _____ Patient/Member ID #: _____

2nd Health Plan:_____ Primary Care Physician: _____ PCP phone #: _____
(Required) (Required)

Patient's Primary Language: _____

Please describe your current health problem(s):_____

How and When it began:_____

If you are undergoing acupuncture treatments, describe your progress: _____

☐ Worsened ☐ No change ☐ 25% improved ☐ 50% improved ☐ 75% improved

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

How often are your symptoms present? ☐Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Describe your current health condition: ☐ Good ☐ Fair ☐ Poor ☐ Chronically ill

Can you perform your daily activities? ☐ Yes, all activities ☐ Some activities ☐ Not at all

Are you currently under the care of a physician? ☐ No ☐ Yes, please explain _____

What treatment have you been taking for the above condition(s)? (Surgery, medications, injections, therapy, chiropractic, etc.) _____

Please check all of the following that apply to you:

- ☐ Alcohol/tobacco/drug dependence
- ☐ Abnormal menstruation
- ☐ Allergies
- ☐ Angina
- ☐ Arthritis/rheumatoid arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Blood disorder
- ☐ Breast lumps
- ☐ Cancer/tumor
- ☐ Convulsions/seizures
- ☐ Diabetes
- ☐ Diarrhea/constipation
- ☐ Excessive thirst
- ☐ Fainting or dizziness
- ☐ Fatigue
- ☐ Frequent urination
- ☐ Headache
- ☐ Heart attack
- ☐ Heartburn or indigestion
- ☐ Hypertension
- ☐ Hospitalizations/surgical procedures_____
- ☐ Kidney disease
- ☐ Liver problems
- ☐ Pacemaker
- ☐ Painful menstruation
- ☐ Palpitation/arrhythmia
- ☐ Peptic ulcer
- ☐ PMS
- ☐ Pregnancy, months _____
- ☐ Prostate problems
- ☐ Rapid weight gain/loss
- ☐ Sinusitis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ **Medications** _____
- ☐ Other:_____

If a family member has had any of the following, please mark the appropriate box and explain:

- ☐ Lupus
- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Other: _____

Comments:_____

I certify 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 provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my ASH Plans Acupuncture Provider or an ASH Plans Clinical Services Manager may need to contact my PCP or treating physician if my condition needs to be co-managed. Therefore, I give my authorization to ASH Plans to contact my medical doctor if necessary.

Patient signature: _____ **Date:** _____