



Family Chiropractic & Spinal Health Care Center

INITIAL HEALTH STATUS

Patient Name: Birth date: Sex: M / F
Address City State Zip
Home Phone Cell Phone S.S. # Marital Status: S M D W
E-Mail Address Referred By:
Emergency Contact: Emergency Phone
Occupation Employer Work Phone
Address City State Zip
Primary Insurance Company Subscriber S.S. #
Subscriber Name Subscriber Birth Date Self/Spouse/Other
Subscriber ID # Group # Type Health Plan: PPO/POS/HMO
2nd Insurance Company Subscriber S.S. #
Primary Care Physician Name PCP Phone

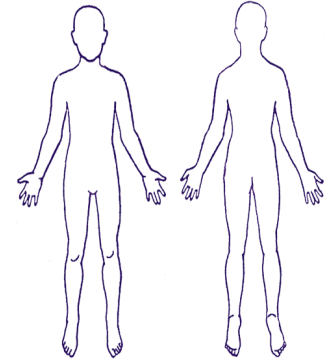
MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

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: Gradual / Sudden

Current complaint (how you feel today):
No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable



How often are your symptoms present?
(Intermittent) 0 - 25% 26 - 50% 51 - 75% 76 - 100% (Constant)

In the past week 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:

Recent fever Prostate Problems Diabetes
Menstrual Problems High Blood Pressure Heart Disease
Urinary Problem Lungs Disease Stroke (date)
Currently pregnant, # Weeks Corticosteroid Use (cortisone, prednisone, etc.)
Abnormal Weight Gain Loss Taking Birth Control Pills Marked Morning Pain/Stiffness
Dizziness/Fainting Pain Unrelieved by Position or Rest Numbness in Groin/Buttocks
Nausea Change in Bowel/Bladder Pain at Night
Cancer/Tumor (explain) Visual Disturbance
Osteoporosis Epilepsy/Seizures Headaches
Allergies Arthritis Asthma
Other Health Problems (explain)

Surgeries Medications

Family History: Cancer Diabetes High Blood Pressure Heart Problem/Stroke
Rheumatoid Arthritis Other

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 future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature Date