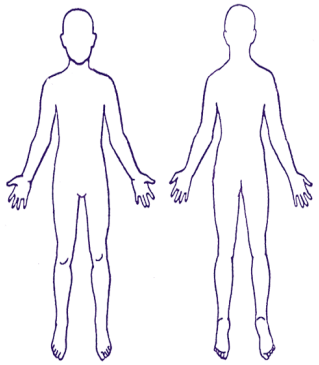
Family Chiropractic &
Spinal Health Care Center

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 _____