

**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 # \_\_\_\_\_  
2<sup>nd</sup> 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 _____<br>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/<br>Rheumatoid Arthritis | <input type="checkbox"/> High Blood Pressure                           | <input type="checkbox"/> Medications _____   |
| <input type="checkbox"/> Artificial Joints                  | <input type="checkbox"/> Hospitalizations/Surgical<br>Procedures _____ |  |
| <input type="checkbox"/> Asthma                             |  |  |
| <input type="checkbox"/> Blood Disorder                     | <input type="checkbox"/> Kidney Disease                                | If a family member has had any of the following, please mark the appropriate box and explain the relationship:<br><input type="checkbox"/> Cancer _____<br><input type="checkbox"/> Heart Disease _____<br><input type="checkbox"/> Hypertension _____<br><input type="checkbox"/> Lupus _____<br><input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Breast Lumps                       | <input type="checkbox"/> Liver Problems                                |  |
| <input type="checkbox"/> Cancer/Tumor                       | <input type="checkbox"/> Osteoporosis                                  |  |
| <input type="checkbox"/> Convulsions/Seizures               | <input type="checkbox"/> Pacemaker                                     |  |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Palpitation/Arrhythmia                        |  |
| <input type="checkbox"/> Diarrhea/Constipation              | <input type="checkbox"/> Peptic Ulcer                                  |  |
| <input type="checkbox"/> Excessive Thirst                   | <input type="checkbox"/> Pregnant, # Weeks _____                       |  |
| <input type="checkbox"/> Fainting or Dizziness              | <input type="checkbox"/> Prostate Problems                             |  |
| <input type="checkbox"/> Fatigue                            | <input type="checkbox"/> Weight Gain/Loss                              |  |
| <input type="checkbox"/> Fever                              | <input type="checkbox"/> Sinusitis                                     |  |
|   |  |  |
|   |  |  |

**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 \_\_\_\_\_

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Height  
weight  
Blood pressure