American Specialty Health Networks, Inc. (ASH Networks)
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INITIAL HEALTH STATUS

(Acupuncture)

For questions, please call ASH Networks at 888.226.8879

Patient Name ____ Birthdate ______________ Sex M / F
Last First

Address ____ City ________________________

State ______ Zip ____________ Telephone (____)____________ Patient Primary Language ______________

Subscriber Name:____________________ Subscriber ID #: ____________Group #:__________________

Phone # (Home):____________Work #: ____________Employer ________________Occupation________

Primary Health Plan: ____________________________ Patient/Member ID #: ________________________

2nd Health Plan:____________ Primary Care Physician: ____________________ (Required) PCP phone #: __________ (Required)

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:

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Lupus
- ☐ Other: ____________________ ______________________

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 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 Networks Acupuncture Provider or an ASH Networks 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 Networks to contact my medical doctor if necessary.

Patient signature: ____ **Date:** ________________