

# INITIAL HEALTH STATUS

Acupuncture and Oriental Medicine  
For questions, please call ASH at 800.972.4226

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Primary Language \_\_\_\_\_ Gender 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 related to a specific work injury?  No  Yes

What treatment have you received for the above condition(s)?  Surgery  Medications  Physical Therapy

Injections  Chiropractic  Therapeutic Massage  Other \_\_\_\_\_

Please describe your progress:  Worse  No Change  0-25% Better  26-50% Better

51-75% Better  76%-100% Better

<b>Circle</b> 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 _____
<b>No Pain</b> 0 1 2 3 4 5 6 7 8 9 10 <b>Unbearable Pain</b>
In the past week, how much has your pain interfered with your daily activities?
<b>No Interference</b> 0 1 2 3 4 5 6 7 8 9 10 <b>Unable to carry on any activities</b>

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

Describe your current health overall:  Excellent  Very Good  Good  Fair  Poor

What are your goals for your acupuncture treatments? \_\_\_\_\_

How will you track your progress towards your goals? \_\_\_\_\_

**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"/> Weight Gain/Loss         |
| <input type="checkbox"/> Abnormal Menstruation                         | <input type="checkbox"/> Headache  | <input type="checkbox"/> Sinusitis                |
| <input type="checkbox"/> Allergies                                     | <input type="checkbox"/> Heart Attack (date _____)   | <input type="checkbox"/> Stroke (date _____)      |
| <input type="checkbox"/> Angina  | <input type="checkbox"/> Heartburn or Indigestion  | <input type="checkbox"/> Tobacco Use - Type _____ |
| <input type="checkbox"/> Arthritis/<br>Rheumatoid Arthritis            | <input type="checkbox"/> High Blood Pressure   | Frequency _____/Day                               |
| <input type="checkbox"/> Artificial Joints (list date and joint) _____ | <input type="checkbox"/> Hospitalizations<br>(date and reason) _____   | <input type="checkbox"/> Thyroid Disease          |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Surgeries (list date and type) _____  | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Blood Disorder                                |  | <input type="checkbox"/> <b>Medications</b> _____ |
| <input type="checkbox"/> Breast Lumps                                  | <input type="checkbox"/> Kidney Disease  |   |
| <input type="checkbox"/> Cancer/Tumor (type and date) _____            | <input type="checkbox"/> Liver Problems  |   |
| <input type="checkbox"/> Convulsions/Seizures                          | <input type="checkbox"/> Osteoporosis  |   |
| <input type="checkbox"/> Diabetes                                      | <input type="checkbox"/> Pacemaker   |   |
| <input type="checkbox"/> Diarrhea/Constipation                         | <input type="checkbox"/> Palpitation/Arrhythmia  |   |
| <input type="checkbox"/> Excessive Thirst                              | <input type="checkbox"/> Peptic Ulcer  |   |
| <input type="checkbox"/> Fainting or Dizziness                         | <input type="checkbox"/> Pregnant, # Weeks _____   |   |
| <input type="checkbox"/> Fatigue                                       | If pregnant, are you under a<br>medical doctor's care? <input type="checkbox"/> Y <input type="checkbox"/> N |   |
| <input type="checkbox"/> Fever   | <input type="checkbox"/> Prostate Problems   |   |

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

- |  |
|--|
| <input type="checkbox"/> Cancer _____        |
| <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Hypertension _____  |
| <input type="checkbox"/> Lupus _____         |
| <input type="checkbox"/> 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 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** \_\_\_\_\_