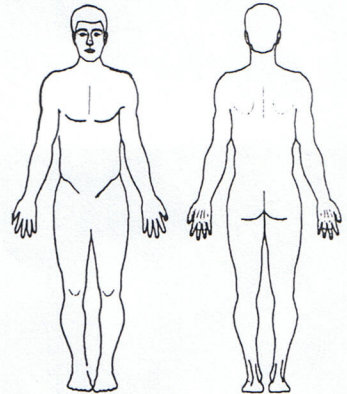


Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____
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:



Is this? Work Related Auto Related N/A

DATE PROBLEM BEGAN: _____

Current complaint (how you feel today):

0	1	2	3	4	5	6	7	8	9	10
No Pain Unbearable Pain										

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

Can you perform your daily activities? Yes No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Yes Date(s) taken: _____

WHAT AREAS WERE TAKEN?

Please check all of the following that apply to you: None Apply

- | No | Yes | Condition | No | Yes | Condition |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills | <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____ | <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks | <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention | <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor | | | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | | | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma | | | _____ |

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

I certify that 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 the future. I understand that my chiropractor or a clinical peer employed by ASH Network 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:** _____