

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M / F  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_  
 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.

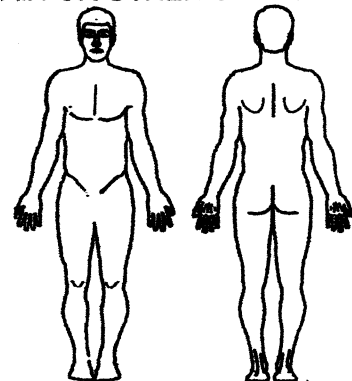
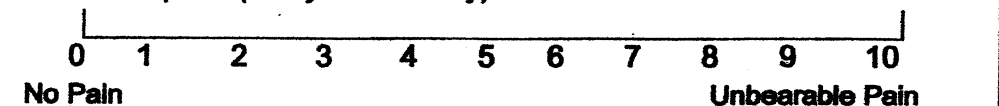
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is this?  Work Related  Auto Related  N/A

DATE PROBLEM BEGAN: \_\_\_\_\_

Current complaint (how you feel today):



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                   |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever                |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use          |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills         |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting          |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks  |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention           |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor                |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma               |

- | No                       | Yes                      | Condition   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures   |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____  |

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 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 \_\_\_\_\_