American Specialty Health Networks (ASH Networks)
P.O. Box 509001, San Diego, CA 92150-9001 Fax: 877/248-2746

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 _____

Subscriber Name:_____ Subscriber ID #: _____Group #:_____

Phone # (Home):_____Work #: _____Employer _____Occupation_____

Social Security #:_____ Primary Health Plan: _____ Patient/Member ID #: _____

2nd Health Plan:_____ Primary Care Physician: _____ PCP phone #: _____
(Required) (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.) _____

Past	Present	
☐	☐	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

Past	Present	
☐	☐	Frequent urination
☐	☐	Headache
☐	☐	Heart attack
☐	☐	Heartburn or indigestion
☐	☐	High blood pressure
☐	☐	Hospitalizations/surgical procedures_____ _____
☐	☐	Kidney disease
☐	☐	Liver problems
☐	☐	Pacemaker
☐	☐	Painful menstruation
☐	☐	Palpitation/arrhythmia
☐	☐	Peptic ulcer
☐	☐	PMS
☐	☐	Pregnancy, months ____
☐	☐	Prostate problems
☐	☐	Rapid weight gain/loss

Past	Present	
☐	☐	Sinusitis
☐	☐	Stroke
☐	☐	Thyroid Disease
☐	☐	**Medications** _____ _____ _____
☐	☐	Other:_____ _____

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

☐ Arthritis ☐ Lupus
☐ Cancer ☐ Mental disorders
☐ Heart disease
☐ Hypertension
☐ Other: _____ _____

Comments:_____

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. 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 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:** _____