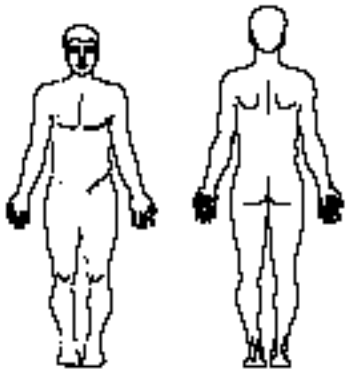
American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Gender: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
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:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began_____
How 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%

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?
No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, 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 practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

Have you had any of the following **pulmonary (lung-related)** issues?
☐ Asthma/difficulty breathing ☐ COPD ☐ Emphysema ☐Other _____ ☐ N/A

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
☐ Heart surgeries ☐ Congestive heart failure ☐ Murmurs or valvular disease ☐ Heart attacks/MIs ☐ Heart disease/problems ☐ Hypertension ☐ Pacemaker ☐ Angina/chest pain ☐ Irregular heartbeat ☐ Other _____ ☐ N/A

Have you had any of the following **neurological (nerve-related)** issues?
☐ Visual changes/loss of vision ☐ One-sided weakness of face or body ☐ History of seizures ☐ One-sided decreased feeling in the face or body ☐ Headaches ☐ Memory loss ☐ Tremors ☐ Vertigo ☐ Loss of sense of smell ☐ Strokes/TIAs ☐ Other _____ ☐ N/A

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
☐ Thyroid disease ☐ Hormone replacement therapy ☐ Injectable steroid replacements ☐ Diabetes ☐ Other _____ ☐ N/A

Have you had any of the following **renal (kidney-related)** issues or procedures?
☐ Renal calculi/stones ☐ Hematuria (blood in the urine) ☐ Incontinence (can't control) ☐ Bladder infections ☐ Difficulty urinating ☐ Kidney disease ☐ Dialysis ☐ Other_____ ☐ N/A

Have you had any of the following **gastroenterological (stomach-related)** issues?
☐ Nausea ☐ Difficulty swallowing ☐ Ulcerative disease ☐Frequent abdominal pain ☐ Hiatal hernia ☐ Constipation ☐ Pancreatic disease ☐ Irritable bowel/colitis ☐ Hepatitis or liver disease ☐ Bloody or black tarry stools ☐ Vomiting blood ☐ Bowel incontinence ☐ Gastroesophageal reflux/heartburn ☐ Other _____ ☐ N/A

Have you had any of the following **hematological (blood related)** issues?
☐ Anemia ☐ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) ☐ HIV positive ☐ Abnormal bleeding/bruising ☐ Sickle-cell anemia ☐ Enlarged lymph nodes ☐ Hemophilia ☐ Hypercoagulation or deep venous thrombosis/history of blood clots ☐ Anticoagulant therapy ☐ Regular aspirin use ☐ Other _____ ☐ N/A

Have you had any of the following **dermatological (skin-related)** issues?
☐ Significant burns ☐Significant rashes ☐ Skin grafts ☐ Psoriatic disorders ☐ Other_____ ☐ N/A

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
☐ Rheumatoid arthritis ☐ Gout ☐ Osteoarthritis ☐ Broken Bones ☐ Spinal fracture ☐ Spinal surgery ☐ Joint surgery ☐ Arthritis (unknown type) ☐ Scoliosis ☐ Metal Implants ☐Other _____ ☐ N/A

Have you had any of the following **psychological** issues?
☐ Psychiatric diagnosis ☐ Depression ☐ Suicidal ideations ☐Bipolar disorder ☐Homicidal ideations ☐ Schizophrenia ☐ Psychiatric hospitalizations ☐ Other _____ ☐ N/A

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Dominion Chiropractic Clinic for services performed. I also understand that I am personally responsible for any and all charges which are incurred as a result of my care at this office.

Patient/Guardian signature _____ Date_____

3904 Meadowdale Blvd
N Chesterfield, VA 23234
dominionchiro@gmail.com
(o) 804-271-7920
(f) 804-271-8538

Dominion Chiropractic Clinic

Name_____DOB_____

SSN_____ Email_____

In the past 5 years:

Major Illnesses_____

Surgeries/Date of procedure(s) _____

Hospitalization/Date_____

Allergies_____

Current medications (dosage and frequency)

_____

_____

_____

Previous injury, trauma, or auto accidents

_____

_____

Any broken bones_____

FAMILY HISTORY	Major Illnesses	Date of Death	Cause
MOTHER	_____	_____	_____
FATHER	_____	_____	_____
SIBLINGS	_____	_____	_____
	_____	_____	_____

Smoking Status ☐ Non-smoker ☐Current smoker ☐Former smoker

Alcohol Use ☐None ☐Casual ☐Moderate ☐Heavy ☐Drinks beer ☐Drinks wine

Recreational Drug Use ☐None ☐Recreational ☐Addiction

Caffeine Intake ☐ None ☐<3 drinks/day ☐3-6 drinks/day ☐>6 drinks/day

Exercise ☐Never ☐Daily ☐Weekly ☐Walks ☐Runs ☐Swims

Race_____ Ethnicity_____ Language_____

Signature_____ Date_____

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Dominion Chiropractic Clinic

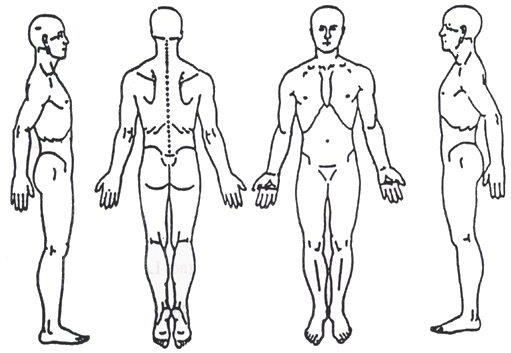
Name _____ Date_____

Functional Rating Index

To properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1.	**Pain Intensity**	0 No pain possible pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst
2.	**Sleeping**	0 Perfect sleep	1 Mildly disturbed sleep	2 Moderately disturbed sleep	3 Greatly disturbed sleep	4 Totally disturbed sleep
3.	**Personal Care** (washing, dressing, etc)	0 No pain; no restrictions	1 Mild pain; no restrictions	2 Moderate pain; need to go slowly	3 Moderate pain; need some assistance	4 Severe pain; need 100% assistance
4.	**Travel** (driving, etc)	0 No pain on long trips	1 Mild pain on long trips	2 Moderate pain on long trips	3 Moderate pain on short trips	4 Severe pain on short trips
5.	**Work**	0 Can do usual work plus unlimited extra work	1 Can do usual work with no extra work	2 Can do 50% of usual work	3 Can do 25% of usual work	4 Cannot work
6.	**Recreation**	0 Can do all activities	1 Can do most activities	2 Can do some activities	3 Can do a few activities	4 Cannot do any activities
7.	**Frequency of pain**	0 No pain	1 Occasional pain 25% of the day	2 Intermittent pain 50% of the day	3 Frequent pain 75% of the day	4 Constant pain 100% of the day
8.	**Lifting**	0 No pain with heavy weight	1 Increased pain with heavy weight	2 Increased pain with moderate weight	3 Increased pain with light weight	4 Increased pain with any weight
9.	**Walking**	0 No pain any distance	1 Increased pain after 1 mile	2 Increased pain after ½ mile	3 Increased pain after ¼ mile	4 Increased pain with all walking
10.	**Standing**	0 No pain after several hours	1 Increased pain after several hours	2 Increased pain after 1 hour	3 Increased pain after ½ hour	4 Increased pain with any standing

Patient's signature_____ Date_____



Please indicate problem areas on the chart

(pain- XXX, numbness- NNN, tingling- TTT)

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