

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M / F  
Last First  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_  
 Phone # (Home) \_\_\_\_\_ Work # \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Primary Health Plan \_\_\_\_\_ Patient/Member ID # \_\_\_\_\_  
 2<sup>nd</sup> 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** \_\_\_\_\_