American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

INITIAL HEALTH STATUS

Acupuncture

For questions, please call ASH at 800.972.4226

Patient Name_____ Birthdate_____ Primary Language_____ Sex M / F
(Last) (First)

Address_____ City_____ State____ Zip_____ Primary Phone_____

Employer_____ Occupation_____ Other Phone_____

Subscriber Name_____ Subscriber ID #_____ Group #_____

Primary Health Plan_____ Patient/Member ID #_____

2nd Health Plan_____ Primary Care Physician (PCP)_____ PCP Phone #_____
(Required) (Required)

Are you under the care of a physician? ☐ No ☐ Yes, for what conditions?_____

Please describe your current health problem(s)_____

How and When it began_____ Is this work related? Y / N

What treatment have you received for the above condition(s)? ☐ Surgery ☐ Medications ☐ Physical Therapy ☐ Injections ☐ Chiropractic ☐ Massage ☐ Other_____

Please describe your progress: ☐ Worse ☐ No Change ☐ 25% Better ☐ 50% Better ☐ 75% Better or_____

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**

In the past week, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry on any activities**

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Describe your current health condition: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please check all of the following that apply to you and list any medication(s) you are taking:

- ☐ Alcohol/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
- ☐ Fever
- ☐ Frequent Urination
- ☐ Headache
- ☐ Heart Attack
- ☐ Heartburn or Indigestion
- ☐ High Blood Pressure
- ☐ Hospitalizations/Surgical Procedures_____
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Palpitation/Arrhythmia
- ☐ Peptic Ulcer
- ☐ Pregnant, # Weeks_____
- ☐ Prostate Problems
- ☐ Weight Gain/Loss
- ☐ Sinusitis
- ☐ Stroke
- ☐ Tobacco Use - Type_____ Frequency_____/Day
- ☐ Thyroid Disease
- ☐ Other_____
- ☐ **Medications**_____

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

- ☐ Cancer_____
- ☐ Heart Disease_____
- ☐ Hypertension_____
- ☐ Lupus_____
- ☐ Other_____

Comments_____

I certify that the above information is complete and accurate to the best of my knowledge. 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 provider of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my provider of acupuncture services to contact my medical doctor if necessary.

Patient signature_____ **Date**_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring other patients

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearing and filings
- Reporting to worker's compensation

You have the right to:

- Request a copy of your health record
- Request a list of whom we share your health information with
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your protected health information

These privacy practices are effective April 2003

We may recommend you use, as a part of our treatment program, one or more nutritional supplements. We recommend this supplement or these supplements because we believe your health will benefit from your use of them. We want you to know that, because of our belief in the integrity and effectiveness of these supplements, we are a distributor of these products and, in that role, we may receive a commission from your purchase of these supplements. Please ask to speak with us if you have any concerns about our recommendations in light of this information.

For further information please contact the front desk.

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QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: LIFESTYLE CHIROPRACTIC & WELLNESS
Address: 2091 W. Florida Ave., Suite 120, Hemet, CA 92545
Phones: (951) 929-0100

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this document**

I, _____, have received a copy of the notice of privacy practices of the above named office.

_____ _____

(Signature) (Date)