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

HEALTH STATUS

Massage Therapy Fax: 877.248.2746

Patient Name_____ **Subscriber ID #**_____ **Date**_____

Patient Address_____

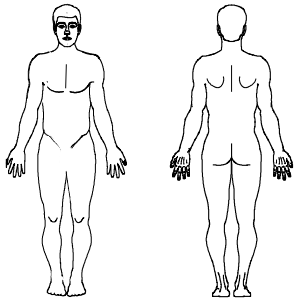
City_____ State_____ ZIP_____

Primary Language_____ **What is your occupation?**_____

Describe Your Current Problem and How It Began_____

Onset date_____

Indicate below where you have pain or other symptoms



Is this? ☐ Work Related ☐ Auto Related ☐ N/A

How often are your symptoms present?

☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your pain:

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

Current complaint (how you feel today):

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 (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

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Cardiac Condition
☐ Stroke (date) _____
☐ Dizziness/Fainting
☐ Cancer/Tumor (explain) _____
☐ Osteoporosis
☐ Other Health Problems (explain)_____
☐ Numbness (location)_____
☐ Urinary Problems
☐ Currently Pregnant, # weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Surgeries_____
☐ Current Medications_____

Who have you seen for your condition before today?

☐ No One ☐ Medical Doctor ☐ Massage Therapist ☐ Other_____
☐ Chiropractor ☐ Physical Therapist ☐ Acupuncturist

What treatment did you receive and when?_____

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 this practitioner may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my practitioner to contact my physician, if necessary.

Patient Signature_____ **Date**_____