

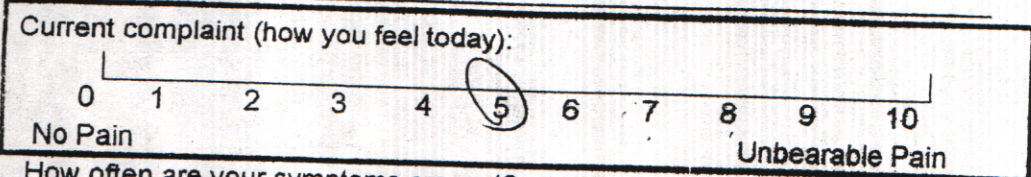
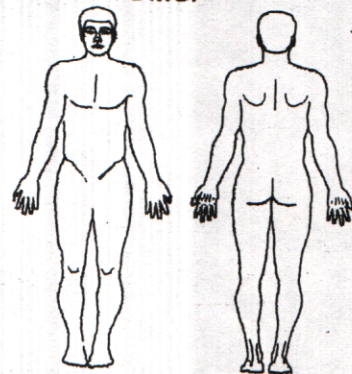
Patient Name Tiffany Anderson Birthdate 8-22-70 Sex M
Address 14116 Tris Drive #7 City Lodi
State CA Zip 95242 Telephone (209) 333-1032 Patient Primary Language English
Occupation auto tech Employer S. J. County Work Phone 982-4675
Address 7759 S. Airport City Stockton State _____ Zip _____
Subscriber 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: _____



How often are your symptoms present?
(Intermittent) 0 - 25% 26 - 50% 51 - 75% 76 - 100% (Constant)

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

DO 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:

- 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 _____
- 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 provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature [Signature] Date 3-21-07