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

CELL PHONE: -

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

Patient Name: Tiffany Anderson Birthdate: 8-22-70 Sex: M / F

Address: 1416 Iris Drive #7 City: Lodi State: CA Zip: 95242

Telephone: 329-2339 Social Security #: 549-23-5133 Driver Lic. #: A4717925

Occupation: Pesticide applicat Employer: SJMVCD Work Phone: 982-4675

Address: 7159 Airport Way City: Stockton State: CA Zip: —

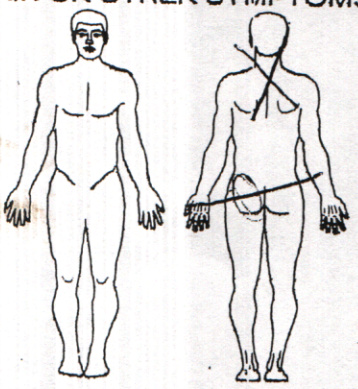
Subscriber Name: Tiffany Anderson Health Plan: Kaiser

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:

Shoulder + neck pain

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

DATE 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%

Can you perform your daily activities? ☒ Yes ☐ No (Describe) —

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☒ No ☐ Yes **Date(s) taken:** —

WHAT AREAS WERE TAKEN? —

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition
☒	☐	History of Recent Infection
☒	☐	Recent Fever
☒	☐	HIV/AIDS
☒	☐	Diabetes
☒	☐	Corticosteroid Use
☒	☐	Birth Control Pills
☒	☐	High Blood Pressure
☒	☐	Stroke (date) —
☒	☐	Dizziness/Fainting
☒	☐	Numbness in Groin/Buttocks
☒	☐	Urinary Retention
☒	☐	Aortic Aneurysm
☒	☐	Cancer/Tumor
☒	☐	Osteoporosis
☒	☐	Recent Trauma

No	Yes	Condition
☒	☐	Prostate Problems
☒	☐	Frequent Urination
☐	☒	Pregnancy, # of births 2
☒	☐	Abnormal Weight ☐ Gain ☐ Loss
☒	☐	Epilepsy/Seizures
☒	☐	Visual Disturbances
☐	☒	History of Low/Mid Back Pain
☐	☒	History of Neck Pain
☒	☐	Arthritis
☒	☐	History of Alcohol Use
☒	☐	History of Tobacco Use
☒	☐	Surgeries/Medications: —

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

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 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: — **Date:** 9-5-06