American Specialty Health (ASH)
P.O. Box 509077, San Diego, CA 92150-9077

INITIAL HEALTH STATUS

PTOTST Fax: 877.248.2746

Patient Name _____ Date of Birth: _____ Age: _____ Date _____

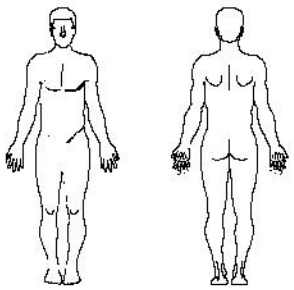
Describe Your Current Problem and How It Began _____

_____

_____

Onset date/Surgery 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

Check if you have difficulty: ☐ Seeing ☐ Hearing ☐ Talking ☐ Memory ☐ Swallowing

What is your most effective learning method: ☐ Seeing ☐ Hearing ☐ Talking ☐ Doing ☐ Pictures

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken _____ **What areas were taken?** _____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ 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 _____
_____
☐ Tobacco Use - Type _____
Frequency _____/Day
☐ Current Medications _____
_____

Who have you seen for your condition before today?

☐ No One ☐ Medical Doctor ☐ Massage ☐ Other _____
☐ Chiropractor ☐ Physical Therapist ☐ Acupuncturist ☐ Occupational Therapist ☐ Speech Therapist

What treatment did you receive and when? _____

What is your Occupation? _____

Work status: FT PT Retired Not Working Primary Care Physician: _____

Have you had this before? Y N What helped you: _____

What makes symptoms better? _____

What makes symptoms worse? _____

PLEASE TURN OVER

Check any of the following which you cannot do for 20 min comfortably:

Sit		**Walk**		**Normal Job Duties**		**Sleep**		**House Work**	
Stand		**Drive**		**Carry 20 lbs.**		**Use Computer**		**Yard Work**	

Check any of the following you cannot do with your normal ability:

Climb Stairs		**Move from sit to stand**		**Get in/out of car**	
Reach overhead		**Move from floor to standing**		**Feed yourself**	
Lift 5-10 lbs. overhead		**Pick 10-20 lbs. up from floor**		**Use utensils**	
Bathe and groom self		**Move in bed**		**Chew**	
Dress yourself					

Do you have any metal implants/pacemakers Y N

Have you recently noted any of the following:

	Yes	No
Weight Loss		
Nausea/Vomiting		
Fatigue		
Weakness		
Fever/Chills/Sweats		
Numbness/Tingling		

	Yes	No
Shooting pain both arm or legs		
Persistent Cough		
Dizziness		
Headaches		
Blurred Vision		
Blood in stool		

Please rate the following:

	0 – Never	1 – Several Days	2 – More than 50% of the Time	3 – Every Day
I have little interest or pleasure in doing things.				
I often feel down, depressed, or hopeless.				

Please list all medications you are currently taking:

MEDICATION	DOSAGE	TIMES PER DAY	REASON FOR MEDICATION

Has your physician discussed your condition with you? Y N

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

_____ _____

Signature **Date**

_____ _____

Printed Name **Date**