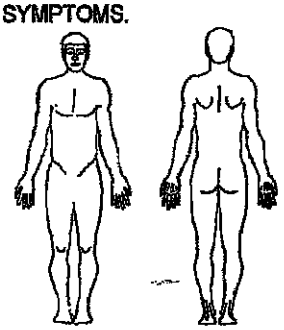
American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex:
Address_____ City_____
State_____ Zip_____ Phone _____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ 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_____

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?
(Occasional) ☐ 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

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE 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:

- ☐ Alcohol/Drug Dependence
- ☐ 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)_____
- ☐ Pace-Maker
- ☐ 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_____
- ☐ Tobacco Use - Type_____ Frequency_____/Day
- ☐ 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 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 my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

1862 Craigshire Rd. Saint Louis, MO 63146 Telephone: (314) 628-9898

Patient Acknowledgement
For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

_____, hereby states that by signing this Consent I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing the Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is also provided in the lobby and on the Practice's website at www.hpc-stl.com. I may also request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____ _____
Signature of Legal Representative Date Signed Relationship

_____
Witness

HEALTH & PERFORMANCE CENTER

1352 Craigshire Rd. Saint Louis, MO 63146 Telephone: (314) 628-8898

Consent to Chiropractic Services

1. I, _____, authorize the performance upon myself of the following procedure(s): Chiropractic Adjustments, Tractioning (to restore normal curves), Posture Specific Exercises, and/or any other therapeutic procedures other than those stated above that HPC Physicians and/or assistants may consider necessary or advisable in the course of my health care.

2. The nature and purpose of the procedures, possible alternatives, risks involved, the possible consequences, and the possibility of complications have been explained to my satisfaction by HPC Physicians and/or assistants.

3. I acknowledge that no guarantee or assurance of the results that may be obtained from the procedures has been given by HPC Physicians and/or assistants.

Date: _____ Signed: _____

Witness: _____

HEALTH & PERFORMANCE CENTER

1862 Craigshire Rd.| St Louis MO 63146

Health & Performance Center
Release of Records

I, _____
Print Name Sign Name Date

Hereby authorize the release of my medical records and/or x-rays (or copies of)

To/From:

Dr, _____

Health & Performance Center
1862 Craigshire Rd.
St. Louis MO 63146

Phone: (314) 628.9898
Fax: (314) 628.9728

To/From:
Dr._____

Address:_____

City: _____ State:_____ Zip:_____

Phone: _____
Fax: _____

HEALTH & PERFORMANCE CENTER

Perfect Plan Survey

Name:_____

Your answers will help the doctor provide a plan that is specifically tailored to your desire.

Question #1 – How well do HPC hours fit with your schedule? (circle one)

Monday & Wednesday – 7:45 to 11:30 and 3:00 to 6:00 (*early and late*)
Tuesday – 8:30 to 3:00 Thursday – 11:00 to 3:00 (*lunch*)
Friday – 8:00 to 12:00 (*combo*)

They fit great **They're good** **They're tough** **They're very difficult**

Question #2 – How severe/annoying is your problem? (circle one)

Not too bad **Starting to affect me** **Definitely getting in the way** **It is TERRIBLE**

Question #3 – How badly do want your problem to go away? (circle one)

It would be nice **It would help a lot** **It needs to be gone** **I am desperate**

Question #4 – What type of care are you interested in? (circle one)

Relief – Pain is relieved
Relief & Correction – Pain goes away and the cause of the pain is addressed
Relief, Correction & Maintenance – Pain can stay away; causative factors are constantly addressed

Relief **Relief & Correction** **Relief, Correction & Maintenance**

Question #5 – How long do you believe it will take to achieve your answer to question #4

Days **Weeks** **Months** **Years**

Question #6 – In order to manage your care as effectively as possible, we would like to have the name of your primary care physician. If you have an internist or family practice medical/osteopathic/naturopathic doctor, please provide as much of the following informaiton as you can.

PCP Name:_____ General Location:_____

Office/Group Name:_____ Phone/email/website:_____

Patient Information

Name:

First_____**M.I.**_____**Last**_____

Birthday:

Month_____**Day**_____**Year**_____

Contact Information:

Home #_____

Cell #_____

Email_____

Referred By:

_____

Address:

City_____**State**_____**Zip**_____

Employer:

Status_____**Occupation**_____

Employer_____

Employer Address:

City_____**State**_____**Zip**_____