American Specialty Health (ASH)
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INITIAL HEALTH STATUS

Chiropractic

Rowena Chiropractic * Dr. Theresa FitzGerald, DC

2904 Rowena Ave, Los Angeles, CA 90039 * 323-660-2370

First Name ______ **Middle Initial** ______ **Last Name** ______

Describe current problem and how began:

- ☐ Headache
- ☐ Neck Pain
- ☐ Mid-Back Pain
- ☐ Low Back Pain

If other, specify where ______

Is this?

○ Work Related ○ Auto Related ○ N/A

Date Problem Began ______ **How Problem Began?** ______

Have you had this problem in the past? ______ **Treatment/Home Remedies** ______ **Response** ______

Current complaint (how you feel today)

○ No Pain 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 Unbearable Pain

How often are your symptoms present?

○ 0-25% Occasional ○ 26-50% Intermittent ○ 51-75% Frequent ○ 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?** ______ **Results** ______

Please check all of the following that apply

- ☐ Alcohol/Drug Dependence
- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (Specify date below)
- ☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting

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- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (Explain below)
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant (# of weeks below)

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- ☐ Abnormal Weight (select gain/loss below)
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Surgeries (specify below)
- ☐ Tobacco Use (specify below)
- ☐ Medications (specify below)

Explain Other Health Problems

Date of Stroke

Explain Cancer/Tumor

# of Weeks Pregnant

Abnormal Weight

- Gain
- Loss

Patient Smoking Status

Patient Smoking Frequency

Other Tobacco

Tobacco Frequency

Rate your current stress level:

No Stress 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 Unbearable

Hours of sleep

Amount of Caffeine

Amount of Alcohol

List Exercise and frequency

List Surgeries

List Medications

Family History

- [ ] CHECK if none apply

Cancer

List Who

Type of Cancer

Heart Problems/Stroke

List Who

Diabetes

List Who

Rheumatoid Arthritis

List Who

High Blood Pressure

List Who

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.

Date

Patient Signature