American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

INITIAL HEALTH STATUS

Acupuncture and Oriental Medicine
For questions, please call ASH at 800.972.4226

Patient Name_____ (Last / First) Birthdate_____ Primary Language_____ Sex M / F

Address_____ City_____ State____ Zip_____ Primary Phone_____

Employer_____ Occupation_____ Other Phone_____

Subscriber Name_____ Subscriber ID #_____ Group #_____

Primary Health Plan_____ Patient/Member ID #_____

2nd Health Plan_____ Primary Care Physician (PCP)_____ (Required) PCP Phone #_____ (Required)

Are you under the care of a physician? ☐ No ☐ Yes, for what conditions?_____

Please describe your current health problem(s)_____

How and When it began_____ Is this work related? Y / N

What treatment have you received for the above condition(s)? ☐ Surgery ☐ Medications ☐ Physical Therapy ☐ Injections ☐ Chiropractic ☐ Massage ☐ Other_____

Please describe your progress: ☐ Worse ☐ No Change ☐ 25% Better ☐ 50% Better ☐ 75% Better or_____

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other_____

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?

No Interference 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry on any activities**

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Describe your current health condition: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please check all of the following that apply to you and list any medication(s) you are taking:

- ☐ Alcohol/Drug Dependence
- ☐ Abnormal Menstruation
- ☐ Allergies
- ☐ Angina
- ☐ Arthritis/ Rheumatoid Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Breast Lumps
- ☐ Cancer/Tumor
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Diarrhea/Constipation
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Frequent Urination
- ☐ Headache
- ☐ Heart Attack
- ☐ Heartburn or Indigestion
- ☐ High Blood Pressure
- ☐ Hospitalizations/Surgical Procedures_____
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Palpitation/Arrhythmia
- ☐ Peptic Ulcer
- ☐ Pregnant, # Weeks_____
- ☐ Prostate Problems
- ☐ Weight Gain/Loss
- ☐ Sinusitis
- ☐ Stroke
- ☐ Tobacco Use - Type_____ Frequency_____/Day
- ☐ Thyroid Disease
- ☐ Other_____
- ☐ **Medications**_____

If a family member has had any of the following, please mark the appropriate box and explain the relationship:

- ☐ Cancer_____
- ☐ Heart Disease_____
- ☐ Hypertension_____
- ☐ Lupus_____
- ☐ Other_____

Comments_____

I certify that the above information is complete and accurate to the best of my knowledge. 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. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my practitioner of acupuncture services to contact my medical doctor if necessary.

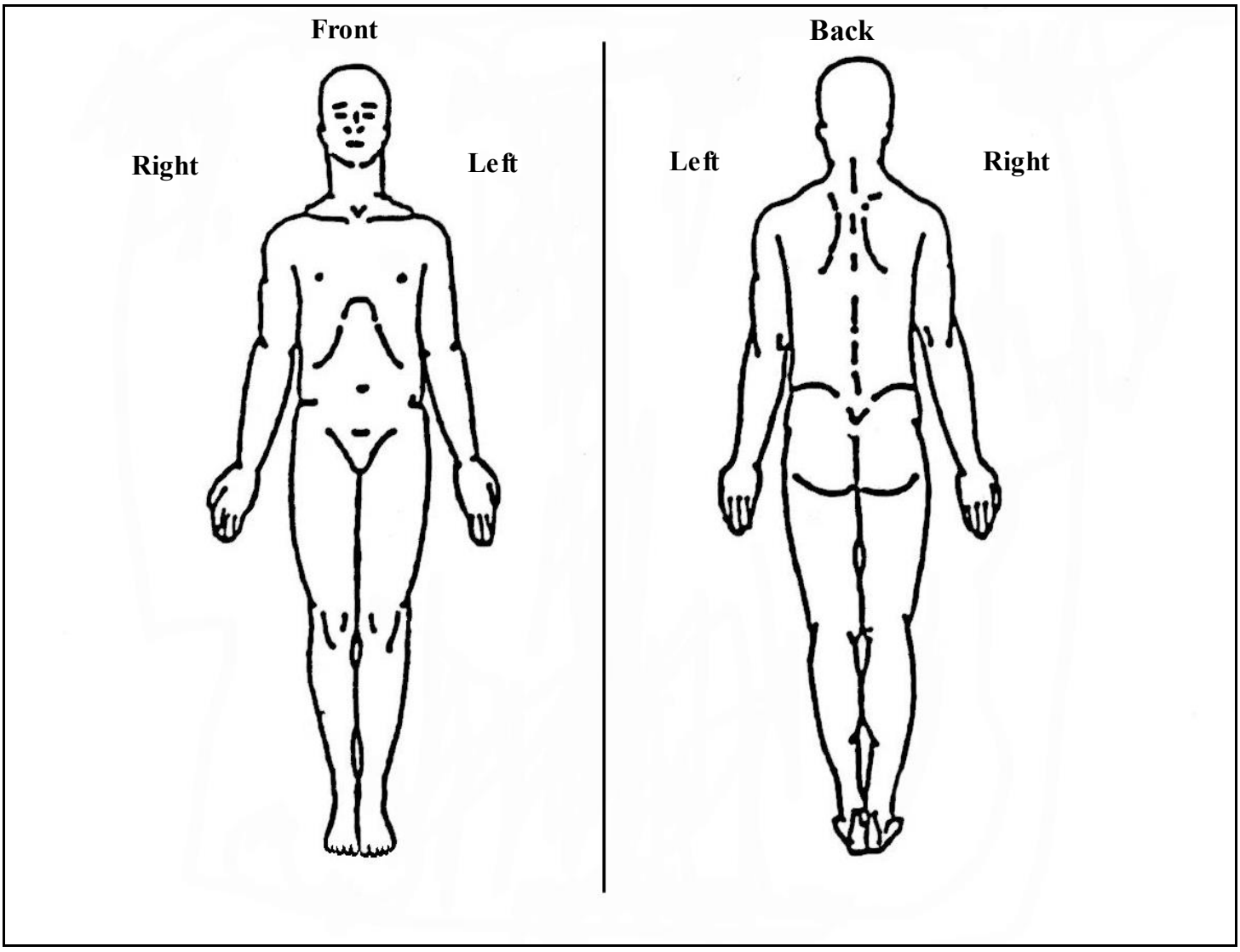
Patient signature_____ **Date**_____

NAME_____ **Date** _____

Mark in the areas of your body that you now feel your typical pain. Include all affected areas.

Use the appropriate symbols indicated below:

Pain = XXXXX **Numbness = OOOOO** **Pins and Needles ===== ====** **Stabbing //////////**



Please mark on line: How bad is your pain now on a scale from 0-10

0----------10

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.
In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.
Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:
In administering your health care, we gather and maintain information that may include non-public personal information.:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g*. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).
We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 805-200-3133

Yours truly,

Daniel Regan L.Ac.
Licensed Acupuncturist

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations

- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice

- The Practice reserves the right to change the Notice of Privacy Policies

- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions

- The patient may revoke this Consent in writing at any time and all future disclosures will then cease

- The Practice may condition treatment upon the execution of this Consent.

Printed Name - Patient or Representative

Signature

_____

_____

The next few pages are for the Treating Acupuncturist to fill out.

Patients do not need to fill anything else out at this time.

CLINICAL TREATMENT FORM -Page 2 (OPTIONAL)

Acupuncture Clinical Findings

Patient Name_____ Occupation_____ Provider Name_____

Pain Descriptions:

Pain Condition #1: Location _____ Intensity (1-10) _____ Frequency_____ Duration_____ hours/days
Pain is ☐Sharp ☐Dull ☐Stabbing ☐Burning ☐Spasmodic ☐Tingling ☐Throbbing ☐Stiffness ☐Distension or _____
Aggravating factors:_____ Alleviating factors:_____

Pain Condition #2: Location _____ Intensity (1-10) _____ Frequency _____ Duration_____hours/days
Pain is ☐Sharp ☐Dull ☐Stabbing ☐Burning ☐Spasmodic ☐Tingling ☐Throbbing ☐Stiffness ☐Distension or _____
Aggravating Factors:_____ Alleviating Factors:_____
Other Pain Conditions:_____

Clinical Findings Related to Pain Location:

Head:
Pain with ☐Nausea/Vomiting ☐Fever/Chills ☐Dizziness ☐Phono/Photophobia ☐Neck Rigidity
Neurologic Deficit ☐Sensation ☐Strength ☐Speech ☐Vision ☐Hearing ☐Cognition ☐Memory ☐Eye Motion/Pupils React

Neck:
Tenderness at _____ ☐Mild ☐Moderate ☐Severe ☐Worsened. Muscle Spasm ☐Mild ☐Moderate ☐Severe
Postural Abnormalities_____ Radiating Pain To_____
Functional Limits_____

Back:
Tenderness at _____ ☐Mild ☐Moderate ☐Severe ☐Worsened. Muscle Spasm ☐Mild ☐Moderate ☐Severe
Postural Abnormalities _____ ☐Scoliosis _____ Radiating Pain To_____
Functional Limits_____

Extremities, Hip(s) and Shoulder(s)
Tenderness at _____ ☐Mild ☐Moderate ☐Severe ☐Worsened. Muscle Spasm ☐Mild ☐Moderate ☐Severe
Swelling _____ Color change _____ Deformity _____ Radiating pain to_____
Functional Limits_____

Neurologic Deficit Location _____ ☐Weakness ☐Abnormal Sensation ☐Reflexes (Increased/Decreased)

ROM of Affected joint(s) Use measurement or indicate if ROM Within Normal Limits (WNL), mildly, moderately or severely limited:

Joints	Flexion / Extension	Lateral Flexion R / L	Rotation R / L	Rotation Int./Ext.	Abduction / Adduction	Other:

Orthopedic/Neurological Test Findings: E.g., Axial Compression _____ ; Patrick's (Fabere) _____ ; Straight Leg Raising_____

Abdominal Pain:
Associate Symptoms: ☐Fever ☐Nausea/Vomit ☐Gas/Distension ☐Heartburn/Reflux ☐Constipation ☐Diarrhea or_____
Palpable Mass at _____Tenderness at_____ Rebound Tenderness_____
Bowel Movement Sounds (Increase/Decrease)_____ Other Findings_____

Menstrual Pain: Menstrual Cycle_____ days. Other Symptoms_____

Additional Clinical Findings (including Lab / Radiographic Exams)_____

Outcome Assessments (List both Initial and Current date(s) with score(s) for applicable tests)

	Initial	Current		Initial	Current
List Date Obtained	____ / ____ / ____	____ / ____ / ____	**List Date Obtained**	____ / ____ / ____	____ / ____ / ____
Roland-Morris score			Neck Disability Index score		
Oswestry score			LEFS (Lower Extrem.) score		
Pain scale (0-10) score			DASH (Upper Extrem.) score		
Other_____			Other_____		

Signature of treating acupuncture provider_____ **Examination Date (required)**_____

ACUPUNCTURE SPORTS INJURY AND WELLNESS CLINIC

Patients Name:_____

Subjective:Pt c/o Pain Spasm ↓range of motion: in the Head Cervical Thoracic Lumbar Extremity

_____

Objective : Spasm Tenderness Trigger Points ↓ Range of motion ↑ Range of motion

Assessment_____

_____

Plan: Acupuncture E-Stim Tui-na Heat Ice Gua Sha Kinesio Tape Other

Needle points _____for first 15 min - with e-stim without e-stim

Needle Points_____addit 15 min, addit 30 min, addit 45 minutes, with e-stim, without e-stim

Signature_____ Date_____

Patients Name:_____

Subjective:Pt c/o Pain Spasm ↓range of motion: in the Head Cervical Thoracic Lumbar Extremity

_____

Objective : Spasm Tenderness Trigger Points ↓ Range of motion ↑ Range of motion

Assessment_____

_____

Plan: Acupuncture E-Stim Tui-na Heat Ice Gua Sha Kinesio Tape Other

Needle points _____for first 15 min - with e-stim without e-stim

Needle points_____additi 15 min, addit 30 min, addit 45 minutes,with e-stim, without e-stim

Signature_____ Date_____

Patients Name:_____

Subjective:Pt c/o Pain Spasm ↓range of motion: in the Head Cervical Thoracic Lumbar Extremity _____

Objective : Spasm Tenderness Trigger Points ↓ Range of motion ↑ Range of motion

Assessment_____

Plan: Acupuncture E-Stim Tui-na Heat Ice Gua Sha Kinesio Tape Other

Needle points _____for first 15 min - with e-stim without e-stim

Needle points _____addit 15 min, addit 30 min, addit 45 minutes, with e-stim, without e-stim

Signature_____ Date_____

Patients Name:_____

Subjective:Pt c/o Pain Spasm ↓range of motion: in the Head Cervical Thoracic Lumbar Extremity _____

Objective : Spasm Tenderness Trigger Points ↓ Range of motion ↑ Range of motion

Assessment_____

Plan: Acupuncture E-Stim Tui-na Heat Ice Gua Sha Kinesio Tape Other

Needle points _____for first 15 min - with e-stim without e-stim

Needle points _____addit 15 min, addit 30 min, addit 45 minutes, with e-stim, without e-stim

Signature_____ Date_____