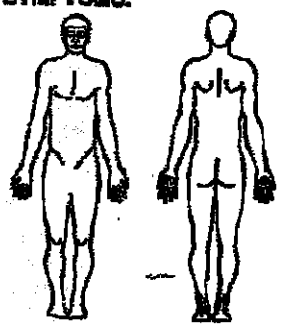
American Specialty Health (ASH)
P.O. Box 509081, San Diego, CA 92150-9081
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex:
Address_____ City_____
State_____ Zip_____ Phone_____ Height_____ Weight_____
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_____

HEALTH & PERFORMANCE CENTER

[illegible] Rd. Saint Louis, MO [illegible] Telephone: [illegible]

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

[illegible] Rd. Saint Louis, MO [illegible] Telephone: (314) [illegible]

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: _____

Patient Information

HEALTH & PERFORMANCE CENTER

Name: _____
First Middle Initial Last

Date of Birth: _____
Month Day Year

Address: _____
Street City State Zip

Referred By: _____

Contact Information:

Home: (_____)_____ Cell: (_____)_____

Work: (_____)_____ Email: _____

Employer:

Your Employer: _____ Your Position: _____

Employer Address: _____
Street City State Zip

HEALTH & PERFORMANCE CENTER

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

Perfect Plan Survey

Name: _____

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

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

Mon & Wed: 7:30am - 11:30am & 2:30pm - 6:00pm

Tue: 11:00am - 2:00pm | Thu: 9:30am - 2:00pm

Fri: 7:30am - 12:00pm

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

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

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

3) How badly do you 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

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

Relief (Pain is relieved)
Relief & Correction (Pain is relieved & cause of pain is addressed
Relief, Correction & Maintenance (Pain can stay away; causative factors are constantly addressed

5) How long do you believe it would take to achieve your answer to question #4? (circle one)

Days • Weeks • Months • Years

6) For some, treatment efficiency and convenience are major concerns. We us TeleCare Rx software to deliver virtual sessions, speeding the recovery process and providing convenience to patients who need it. How interested would you be in this option? (circle one)

Not interested • Somewhat interested • Fairly interested • SIGN ME UP

7) Please provide the following information; a vital component of ensuring an effective care plan

PCP Name: _____ General Location: _____

Office/Group Name: _____ Phone/Email/Website: _____