American Specialty Health Networks (ASHN)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877/304-2746

PATIENT'S PRESENT COMPLAINTS

For questions, please call ASHN at 800/972-4226

Name ______________________________ Date ____________

Address ____________________ City ____________ State ______ Zip ____________

Telephone ____________ Social Security# ____________ Driver Lic.# ____________

Age ________ Birthdate ____/____/____ Sex M / F Status M S W D No. Children ________

Occupation ____________ Employer ____________ Wk Ph. ____________ Years Employed ____

Address ____________________ City ____________ State ______ Zip ____________

Spouse's Name ____________ Occupation ____________ Employer ____________ Soc. Sec.# ____________

Person Responsible for this Account ____________________ Health Plan ____________

Subscriber's Name ____________________ ID# ____________ Group# ____________

WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP)? ______________________________

PLEASE DESCRIBE YOUR CURRENT PROBLEM. ______________________________

____

HOW DID YOUR PROBLEM BEGIN? ______________________________

DATE PROBLEM BEGAN: ____/____/____

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION IN THE PAST? (SURGERY, MEDICATIONS, INJECTIONS, THERAPY, CHIROPRACTIC) ______________________________

____

HAVE YOU HAD X-RAYS, MRI OR OTHER TESTS FOR THIS CONDITION? WHAT TESTS AND WHEN? ____________

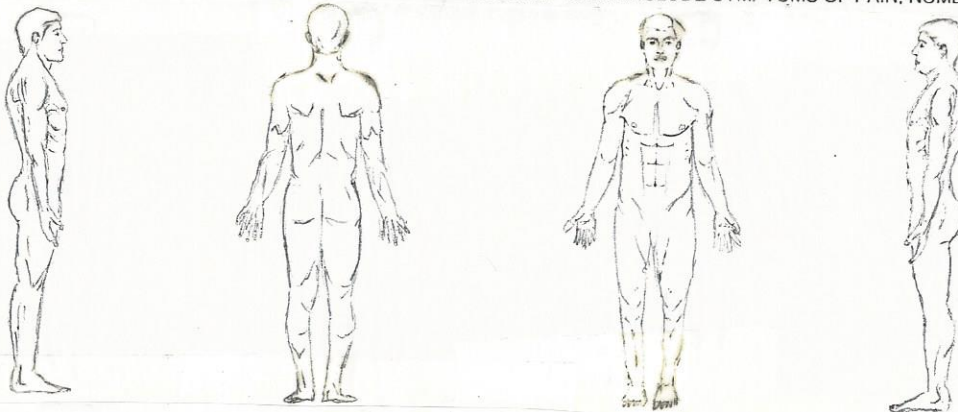
____

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain ... Unbearable Pain

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

Describe your current pain/symptoms:	☐ Sharp/Stabbing ☐ Dull ☐ Numbness ☐ Burning	☐ Throbbing ☐ Soreness ☐ Shooting ☐ Tingling	☐ Aches ☐ Weakness ☐ Gripping ☐ Other ________
Since it began, is your problem:	☐ Improving	☐ Getting Worse	☐ No Change
What makes the problem better?	☐ Nothing ☐ Standing ☐ Exercise	☐ Lying Down ☐ Sitting ☐ Inactivity/rest	☐ Walking ☐ Movement ☐ Other ________
What makes the problem worse?	☐ Nothing ☐ Standing ☐ Exercise	☐ Lying Down ☐ Sitting ☐ Inactivity/rest	☐ Walking ☐ Movement ☐ Other ________
Can you perform your daily home activities?	☐ Yes	☐ Yes, only with help	☐ Not at all
Do you exercise?	☐ Yes, almost daily	☐ Yes, occasionally	☐ Not at all
Describe your job requirements:	☐ Mainly sitting	☐ Light Labor	☐ Heavy Labor
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient Signature: ______________________________ Date: ____________

Pamela M. Traum, D.C. Traum Chiropractic, 2135 E. Southern Ave. Tempe, AZ

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PATIENT HEALTH QUESTIONNAIRE

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Patient Name ______________________________ Patient ID# ____________________

If you have *ever* had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
☐	☐	Abdominal Pain
☐	☐	Abnormal Weight ☐Gain ☐Loss
☐	☐	Angina
☐	☐	Anorexia
☐	☐	Aortic Aneurysm
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bladder Infection
☐	☐	Blood Disorder
☐	☐	Breast ☐Soreness ☐Lumps
☐	☐	Cancer, Explain____________
☐	☐	Chest Pains
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	Colitis
☐	☐	Constipation/irregular bowel habits
☐	☐	Convulsions
☐	☐	Diabetes
☐	☐	Depression
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Difficulty in Swallowing
☐	☐	Dizziness
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Endometriosis
☐	☐	Epilepsy
☐	☐	Excessive Thirst
☐	☐	Fainting
☐	☐	Frequent Urination
☐	☐	General Fatigue
☐	☐	Hand Pain (R_____ L_____)
☐	☐	Headache
☐	☐	Heart Attack (date) ____________
☐	☐	Heartburn/Indigestion
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Irregular Menstral Flow
☐	☐	Irritable Colon
☐	☐	Jaw Pain
☐	☐	Kidney Disorders (by condition)
☐	☐	Kidney Stones
☐	☐	Liver / Gallbladder problems
☐	☐	Loss of Appetite

Past	Present	Condition
☐	☐	Loss of Bladder Control
☐	☐	Low Back Pain
☐	☐	Mid Back Pain
☐	☐	Muscular Incoordination
☐	☐	Neck Pain
☐	☐	Pain in Ankle or Foot (R_____ L_____)
☐	☐	Pain in Lower Leg or Knee (R_____ L_____)
☐	☐	Pain in Upper Arm or Elbow (R_____ L_____)
☐	☐	Pain in Upper Leg or Hip (R_____ L_____)
☐	☐	Painful Urination
☐	☐	PMS
☐	☐	Profuse Menstral Flow
☐	☐	Prostate Problems
☐	☐	Rapid Heart Beat
☐	☐	Rheumatoid Arthritis
☐	☐	Scoliosis
☐	☐	Shoulder Pain (R_____ L_____)
☐	☐	Stroke (date) ____________
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Tinnitus (Ear Noises)
☐	☐	Tumor, Explain____________
☐	☐	Ulcer
☐	☐	Visual Disturbances
☐	☐	Wrist Pain (R_____ L_____)
☐	☐	Other____________

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

☐ Cancer
☐ Rheumatoid Arthritis
☐ Diabetes☐
☐ Heart Problems
☐ Lung Problems ☐ Other____________
☐ High Blood Pressure ____________
☐ Epilepsy
☐ Chronic Back Problems
Chronic Headaches
☐ Lupus

Yes	No	
☐	☐	Do you have a permanent disability rating?
		Location ____________________
☐	☐	Date rating received ____/____/____
☐	☐	Rating Percentage__________%

Present Weight _______pounds **Height** _______feet _______inches

Please check any of the following that apply to you

Past	Present	
☐	☐	Pregnancy, # births____________
☐	☐	Birth Control Pills, type____________
☐	☐	Medications (list if not listed elsewhere) ____________ ____________
☐	☐	Hospitalizations/Surgical Procedures (list if not described elsewhere)____________

Past	Present	
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffinated Soft drinks: cups/cans per day____________

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient's Signature: ______________________________ Date: ____________