

American Specialty Health Plans (ASHP)

P.O. Box 509002, San Diego, CA 92150-9002

Fax: 619-297-1717

PATIENT'S PRESENT COMPLAINTS

For questions, please call ASHP 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 _____ 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# _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date problem began: ____/____/____

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:

<input type="checkbox"/> Sharp/Stabbing	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Aches
<input type="checkbox"/> Dull	<input type="checkbox"/> Soreness	<input type="checkbox"/> Weakness
<input type="checkbox"/> Numbness	<input type="checkbox"/> Shooting	<input type="checkbox"/> Gripping
<input type="checkbox"/> Burning	<input type="checkbox"/> Tingling	<input type="checkbox"/> Other _____

Since it began, is your problem:

<input type="checkbox"/> Improving	<input type="checkbox"/> Getting Worse	<input type="checkbox"/> No Change
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What makes the problem better?

<input type="checkbox"/> Nothing	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Walking
<input type="checkbox"/> Standing	<input type="checkbox"/> Sitting	<input type="checkbox"/> Movement
<input type="checkbox"/> Exercise	<input type="checkbox"/> Inactivity/rest	<input type="checkbox"/> Other _____

What makes the problem worse?

<input type="checkbox"/> Nothing	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Walking
<input type="checkbox"/> Standing	<input type="checkbox"/> Sitting	<input type="checkbox"/> Movement
<input type="checkbox"/> Exercise	<input type="checkbox"/> Inactivity/rest	<input type="checkbox"/> 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

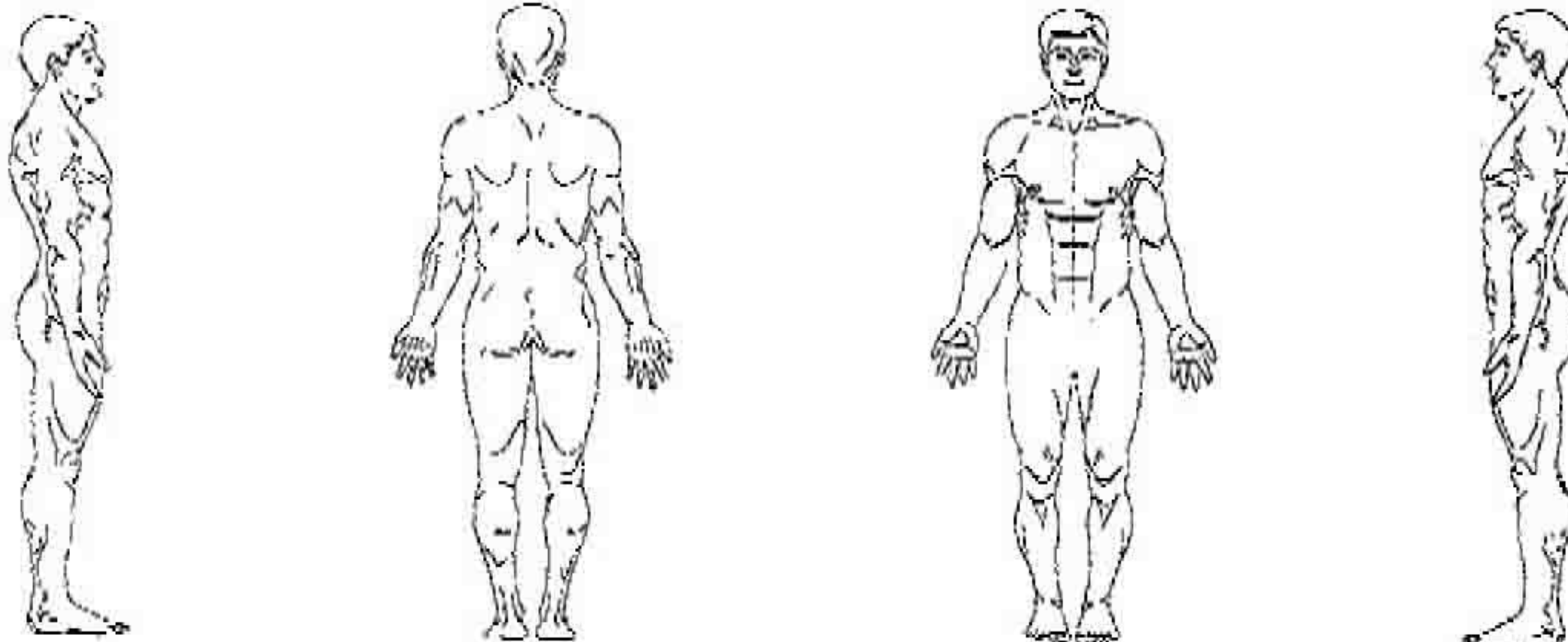
Can you perform your daily work activities? Yes, all activities Only some Not at all

Describe your stress level: None to mild Moderate High

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? _____

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



Patient Signature: _____ Date: _____