

American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

Patient Name _____ Birthdate _____ Sex M / F
 Address _____ City _____
 State _____ Zip _____ Telephone (____) _____ Patient Primary Language _____
 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.

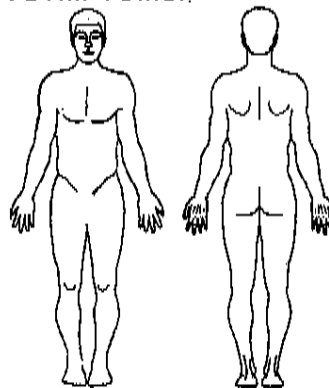
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

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 _____ 10
 No Pain _____ Unbearable Pain

How often are your symptoms present?
 (Intermittent) 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 _____ 10 _____ Unable to carry on any activities

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:

- | | |
|---|--|
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Stroke (date) _____ | <input type="checkbox"/> Currently Pregnant, # weeks _____ |
| <input type="checkbox"/> Corticosteroid Use (cortisone, prednisone, etc.) | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Taking Birth Control Pills | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Cancer/Tumor (explain) _____ | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Medications _____ |
| <input type="checkbox"/> Other Health Problems (explain) _____ | <input type="checkbox"/> _____ |

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 provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature _____ Date _____

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.

PATIENT HEALTH QUESTIONNAIRE - PAGE 2

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Swelling/Stiffness of Joint(s)
<input type="checkbox"/>	<input type="checkbox"/>	Fainting, Visual Disturbances, Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness/Lumps
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge
<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Irregular bowel habits
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash

Please check any of the following that apply to you.

<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills used
<input type="checkbox"/>	<input type="checkbox"/>	Medications (please list them) _____

<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Surgical Procedures (please list them) _____

<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffeinated Soft drinks, cups per day _____

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a permanent disability rating?
		Location _____
		Date rating received ____/____/____
		Rating Percentage _____%

Present: Weight _____ pounds
 Height _____ feet _____ inches

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders)
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Patient's Signature: _____ Date: _____

Grand Lake Health Center...the Chiropractic Office of your choice.....

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at the Grand Lake Health Center we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

* Your photograph or testimonial may be used for public awareness and education.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

*If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Mark Wong

If you would like further information about our privacy policies and practices please contact: Dr. Mark Wong

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please)

Signature

Date

If you are a minor, or if you are being represented by another party

Personal Representative Printed

Personal Representative Signature Date

Description of the authority to act on behalf of the patient.

Informed Consent Document

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment. The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment. As a part of the analysis, examination, and treatment, you are consenting to the following procedures: joint manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural treatment/analysis, ultrasound, hot/cold therapy, vibromassage, cupping, Flexion/Distracton, myofascial therapy, cranial therapy, leg checks and challenges, taping, Other :

The risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray(s) if taken. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options. Other treatment options for your condition may include: • Self-administered, over-the-counter analgesics and rest • Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers • Hospitalization • Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (For MINOR) I hereby request and authorize Dr. Mark J. Wong, D.C. to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:

_____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Mark J. Wong, D.C. and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I also agree to make all scheduled appointments to the best of my ability in a timely fashion. If I am not able to make said appointment, I will call within 24 hours to cancel or reschedule the appointment. If I do not make such preparations I understand that I may be charged a \$25.00 cancellation fee, which is not billable to insurance.

Patient Name: _____ Dated: _____

Signed: _____ Email: _____

Signature of Parent or Guardian if a minor: _____

Email will only be used for communication from my office and will never be shared without your consent.

Dr. Mark J. Wong, D.C. _____ Dated: _____