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

INITIAL HEALTH STATUS

Naturopathy

For questions, please call ASH Networks at 800.972.4226

Patient Name_____ 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 #_____ Second Health Plan_____

Medical Physician or Specialist_____ MD's Phone #_____

Health Concerns (rank by priority) *Example: Headache*	**Onset** *June 2000*	**Frequency** *2-3 times per week*	**Severity** *Mild to Moderate*
1_____			
2_____			
3_____			
4_____			

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

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

Can you perform your daily home/work activities? ☐ Yes ☐ Yes, limited/with help ☐ Not at all

Have you had lab tests, x-rays or other tests for your problem(s)? ☐ No. If Yes, the tests are:_____

_____

List all medications and supplements, daily dosage and how long you've taken them._____

_____

What are your goals for this visit?_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Allergies_____
☐ Angina
☐ Arthritis_____
☐ Asthma
☐ Birth Control, Type_____
☐ Blood Disorder
☐ Bowel Movement____/Day
☐ Cancer/Tumor_____
☐ Chest Pain
☐ Coffee, Tea, or_____
☐ Diabetes_____
☐ Digestive Problems
☐ Dizziness/Fainting
☐ Exercise_____x Per Week
☐ Fatigue
☐ Fever, Recurrent
☐ Frequent Urination
☐ Headache
☐ Heart Attack
☐ Heartburn or Indigestion
☐ High Blood Pressure____/____
☐ Hospitalizations/Surgeries
_____
_____
☐ Kidney Disease
☐ Liver Problems
☐ Osteoporosis
☐ Pacemaker
☐ Palpitation/Arrhythmia
☐ Peptic Ulcer
☐ Pregnancy, # of Births_____
☐ Pregnant, # Weeks_____
☐ Prostate Problems
☐ Rapid Weight Gain/Loss
☐ Seizures
☐ Sinusitis
☐ Stress
☐ Stroke_____
☐ Thyroid Disease
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Visual Disturbances
☐ Other_____
_____
_____

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_____
_____
_____

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 provider, I understand that I am liable for all charges for services rendered and I agree to notify my naturopathic doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature_____ **Date**_____