American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002 Fax: 877/248-2746

INITIAL HEALTH STATUS
(Acupuncture)
For questions, please call ASH Plans at 888/226-8879

Patient Name _____ Birthdate _____ Sex M / F
Last First

Address _____ City _____ State _____ Zip _____

Subscriber Name:_____ Subscriber ID #: _____Group #:_____

Phone # (Home):_____Work #: _____Employer _____Occupation_____

Social Security #:_____ Primary Health Plan: _____ Patient/Member ID #: _____

2nd Health Plan:_____ Primary Care Physician: _____ PCP phone #: _____
(Required) (Required)

Please describe your current health problem(s):_____

How and When it began:_____

If you are undergoing acupuncture treatments, describe your progress: _____

☐ Worsened ☐ No change ☐ 25% improved ☐ 50% improved ☐ 75% improved

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other: _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

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

Describe your current health condition: ☐ Good ☐ Fair ☐ Poor ☐ Chronically ill

Can you perform your daily activities? ☐ Yes, all activities ☐ Some activities ☐ Not at all

Are you currently under the care of a physician? ☐ No ☐ Yes, please explain _____

What treatment have you been taking for the above condition(s)? (Surgery, medications, injections, therapy, chiropractic, etc.) _____

Past	Present	
☐	☐	Alcohol/tobacco/drug dependence
☐	☐	Abnormal menstruation
☐	☐	Allergies
☐	☐	Angina
☐	☐	Arthritis/ rheumatoid arthritis
☐	☐	Artificial joints
☐	☐	Asthma
☐	☐	Blood disorder
☐	☐	Breast lumps
☐	☐	Cancer/tumor
☐	☐	Convulsions/seizures
☐	☐	Diabetes
☐	☐	Diarrhea/constipation
☐	☐	Excessive thirst
☐	☐	Fainting or dizziness
☐	☐	Fatigue

Past	Present	
☐	☐	Frequent urination
☐	☐	Headache
☐	☐	Heart attack
☐	☐	Heartburn or indigestion
☐	☐	High blood pressure
☐	☐	Hospitalizations/surgical procedures_____
☐	☐	Kidney disease
☐	☐	Liver problems
☐	☐	Pacemaker
☐	☐	Painful menstruation
☐	☐	Palpitation/arrhythmia
☐	☐	Peptic ulcer
☐	☐	PMS
☐	☐	Pregnancy, months _____
☐	☐	Prostate problems
☐	☐	Rapid weight gain/loss

Past	Present	
☐	☐	Sinusitis
☐	☐	Stroke
☐	☐	Thyroid Disease
☐	☐	**Medications** _____
☐	☐	Other:_____

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

☐ Arthritis ☐ Lupus
☐ Cancer ☐ Mental disorders
☐ Heart disease
☐ Hypertension
☐ Other: _____

Comments:_____

I certify that 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. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my ASH Plans Acupuncture Provider or an ASH Plans Clinical Services Manager may need to contact my PCP if my condition needs to be co-managed. Therefore, I give my authorization to ASH Plans to contact my medical doctor if necessary.

Patient signature: _____ **Date:** _____

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INFORMED CONSENT AND DISCLOSURE

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INFORMED CONSENT:

_____
Acupuncture Provider

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by the ASH Plans Contracted Provider of Acupuncture Services named above and/or other ASH Plans Contracted Provider of Acupuncture Services who may treat me. I understand that the ASH Plans Contracted Provider of Acupuncture Services will explain all known risks and complications, and I wish to rely on the ASH Plans Contracted Provider of Acupuncture Services to exercise judgement during the course of the procedure, which the ASH Plans Contracted Provider of Acupuncture Services determines is in my best interests. I may request another person of my choice to be present in the treatment room during treatment.

The ASH Plans Contracted Provider of Acupuncture Services has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risk involved. I agree to the ASH Plans Acupuncture Provider's use of this treatment (if indicated).

- **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.
- **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy
- **Indirect Moxibustion** requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. ASH Plans does not allow *direct* moxibustion where burning material contacts the skin.
- **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.
- **Gua Sha** involves scraping over a small area by using a smooth-edged instrument. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed.
- **Tapping, Plum Blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is a likely occurrence. Only single-use needles are used in these procedures.
- **Electrical Stimulation/TENS** uses microcurrent electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.
- **Treatment Using Control Points Ren 1/Du 1.** In very rare cases, the Acupuncture Provider may recommend treatment using acupuncture points near the genital organs. If this is necessary, the Acupuncture Provider will notify me and will provide alternative treatments if I am uncomfortable with treatment using these points. I understand all attempts will be made to assure my privacy.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with my ASH Plans Contracted Provider of Acupuncture Services. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

Authorization for Release of Medical Information: I further understand that my ASH Plans Contracted Provider of Acupuncture Services or an ASH Plans Acupuncture Clinical Services Manager may need to contact my medical physician when the ASH Plans Contracted Provider of Acupuncture Services or an ASH Plans Acupuncture Clinical Services Manager have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to; pregnancy related nausea, pain associated with Multiple Sclerosis, neuromusculoskeletal effects of stroke, pain/nausea related to cancer/tumor, chemotherapy related nausea, pain/nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to ASH Plans to contact my medical physician if/when necessary.

Treatment of Pediatric Patients <3 Years. I understand that treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to ASH Plans to contact my child's medical doctor if/when necessary.

_____
Patient Name (please print)

_____
Patient ID Number

_____
Primary Care Physician (or specialist) Name

_____
Patient Signature

_____
Primary Care Physician (or specialist) Telephone

_____
Date