DR. MICHAEL E. TUCCI, D.C.

American Specialty Health Plans of California, Inc. (ASH Plans)

Patient Name _____ Birthdate _____ Sex M / F

Address _____ City _____

State _____ Zip _____ Telephone (___) _____ Patient Primary Language _____

Occupation _____ Employer _____ Work Phone (___) _____

Address _____ City _____ State _____ Zip _____

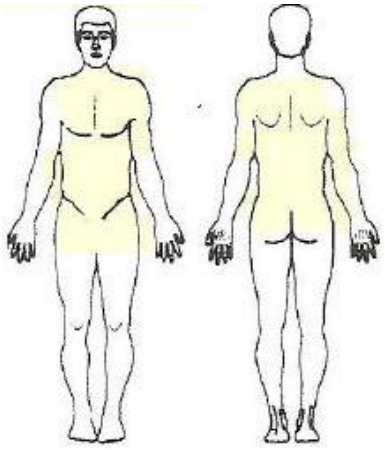
Subscriber Name _____ Health Plan _____

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 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present? (Intermittent) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100 (Constant)

In the week, how much has your pain interfered with your daily activities work, activities, or household chores?

No interference **0 2 3 4 5 6 7 8 9 10** Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREAS OF COMPLAINT? ☐ NO ☐ YES

Date(s) taken: _____ What areas were taken? _____

Please check all of the following that apply to you:

☐ Recent fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) _____
☐ Corticosteroid use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness and Fainting
☐ Numbness in Groin/ Buttocks
☐ Visual Disturbances
☐ Epilepsy/Seizures
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Osteoporosis

☐ Cancer/Tumor (Explain) _____

☐ Surgeries _____

☐ Medications _____

☐ Other Health Problems _____

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 healthcare 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 me co-managed. Therefore, I give authorization to my chiropractor and/or ASH plans to contact my physician, if necessary.

Patient's signature _____ **Date** _____