HANDY CHIROPRACTIC
4100 CAMPUS DR #130
NEWPORT BEACH, CA 92660
949-252-1228

Today's Date: _____

Referred by: _____

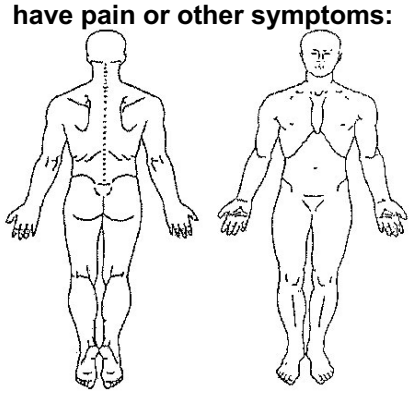
PATIENT NAME_____BIRTHDATE_____SEX M / F
ADDRESS_____CITY_____ STATE_____ZIP_____
HOME PHONE_____E-MAIL _____
CELL PHONE_____Do you want text appointment reminders? Y / N Cell Carrier_____
EMPLOYER_____OCCUPATION_____WORK PHONE_____
HEALTH PLAN_____MEMBER ID_____
Emergency Contact Name _____Relation _____Phone _____

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: _____
Type of pain: (circle) Burning Dull-Ache Sharp Shooting Tight Other: _____

Mark an X on the picture where you have pain or other symptoms:



How would you rate your pain today?

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

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

Have you had a Spinal X-Ray, MRI, CT scan for you area(s) of complaint? Yes/ No
If yes: Date Taken: _____ What areas were taken? _____

Check all of the following that apply to you:

☐ Recent fever
☐ Dizziness/Fainting
☐ Visual Disturbances
☐ Corticosteroid Use (cortisone, prednisone, etc)
☐ High Blood Pressure
☐ Morning Pain/Stiffness
☐ Prostate Problems
☐ Urinary Problems
☐ Stroke (date) _____
☐ Abnormal Weight gain/loss
☐ Epilepsy/Seizures
☐ Pain unrelieved by position/rest
☐ Taking Birth Control Pills
☐ Menstrual Problems
☐ Currently Pregnant, # weeks____
☐ Osteoporosis
☐ Numbness *(area _____)*
☐ Pain at Night
☐ Cancer/Tumor (explain)_____
☐ Surgeries (explain)_____
☐ Medications_____
☐ Other Health Problems _____

Family History: (check all that apply)

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Arthritis

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree to notify the doctor whenever I have changes in my health condition or health plan coverage in the future. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. Additionally, I understand that if I fail to give the office 24-hour notice for cancellation, I am responsible for a $50 missed-appointment fee. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Signature_____ ***Date***_____