**Arkansas Upper Cervical Center**

Clinical Record

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle the symptoms which you are currently suffering with.

|  |  |  |  |
| --- | --- | --- | --- |
|  **GENERAL** |  **E.E.N.T.** | **NERVE** |  **URINARY** |
|  Headaches |  Nearsighted | Weakness |  Frequency |
|  Fainting Spells |  Farsighted | Numbness |  Chronic Infections |
|  Loss of Sleep |  Crossed Eyes | Tingling |  Bloody Urine |
|  Fatigue |  Eye Pain | Twitches |  Kidney Infections |
|  Weight Loss |  Deafness | Tremors |  Kidney Stones |
|  Weight Gain |  Nose Bleeds | Convulsions |  Bed Wetting |
|  Sinuses |  Sore Throat | Seizures |  Loss of Control |
|  Dizziness |  Hay Fever |  |  UTI |
|  Allergies |  Asthma | **WOMEN** |  |
|  Anxiety |  Ear Pain | Painful Cramps |   **HEART** |
|  Depression |  Ear Infection | Excessive Flow |  High Blood Pressure |
|  |  | Hot Flashes |  Low Blood Pressure |
|  **MUSCLE/JOINT** |  **GASTROINTESTINAL** | Irregular Cycle |  Chest Pain |
|  Low Back Pain |  Digestion Difficulty | Discharges |  Ankle Swelling |
|  Hip Pain |  Belching or Gas | Breast Lumps |  Poor Circulation |
|  Shoulder Pain |  Nausea | Painful Breasts |  Previous Stroke |
|  Neck Pain |  Vomiting Blood | Vaginal Itch |  Irregular Heartbeat |
|  Hand, Wrist Pain |  Stomach Pains |  |  Blockage |
|  Painful Tail Bone |  Constipation | **SKIN** |  Stents |
|  Muscle Aches |  Diarrhea | Itching |  |
|  Arthritis |  Irritable Bowel | Bruising |  **RESPIRATORY** |
|  Scoliosis |  Hemorrhoids | Dryness |  Chronic Cough |
|  TMJ |  Acid Reflux | Rash |  Spitting up Phlegm |
|  Sciatica |  Hernia | Varicose Veins |  Spitting up Blood |
|  Neck Stiffness |  | Sensitive Skin |  Chest Pain |
|   |  | Hives  |  Difficulty Breathing |
|   |  | Acne |  Shortness of Breath |
|  |  |  |  |
| **MEN ONLY** | **WOMEN ONLY** |  | **EXERCISE** |
| Testicular Pain | Date of Last Menstrual Period \_\_\_\_\_\_\_\_\_\_\_ |  | 1-3 times/wk |
| Prostate Pain | Date of Last Pap Smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | 1-3 times/month |
| Frequent Urination | Name of Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | 5-6 times/month |
|  |  |  | Never |

**Surgeries:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who in your family has suffered from the following?

Ex: mom, dad, brother, sister Do you smoke? Yes/No

Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, how much/day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drink caffeine? Yes/No

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, how much/day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High/Low Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drink alcohol? Yes/No

Thyroid \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, how much/day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_