ARKANSAS UPPER Cervical CENTER

Name: _____ Date: _____

Primary health complaint: _____

Current Diagnosis/Diagnoses: _____

_____

Please circle the symptoms you currently have

GENERAL
Headaches
Fainting Spells
Loss of Sleep
Fatigue
Weight Loss/Gain
Sinuses
Dizziness
Allergies
Anxiety
Depression

WOMEN'S ISSUES
Painful Cramps
Excessive Flow
Hot Flashes
Irregular Cycle
Discharges
Breast Lumps
Painful Breasts
Vaginal Itch
Mood Swings
Poor Sleep

MUSCLE/JOINT
Neck Pain/Stiffness
TMJ
Shoulder Pain
Elbow Pain
Hand/Wrist Pain
Scoliosis
Low Back Pain
Hip Pain
Painful Tail Bone
Sciatica
Knee Pain
Foot Pain
Muscle Aches
Arthritis

RESPIRATORY
Chronic Cough
Spitting Up Phlegm
Spitting Up Blood
Chest Pain
Difficulty Breathing
Shortness of Breath

E.E.N.T.
Nearsighted
Farsighted
Crossed Eyes
Eye Pain/Pressure
Deafness
Nose Bleeds
Sore Throat
Tonsil Issues
Hay Fever
Asthma
Ear Pain
Ear Infections

URINARY
Frequency
Bladder Infections
Bloody Urine
Kidney Infections
Kidney Stones
Bed Wetting
Loss of Control
Chronic UTI

GASTROINTESTINAL
Digestion Difficulty
Belching/Gas
Nausea
Vomiting Blood
Stomach Pains
Ulcer
Constipation
Diarrhea
IBS
Hemorrhoids
Acid Reflux
Hernia
Chron's Disease

SKIN
Itching
Bruising
Dryness
Rash
Sensitive Skin
Hives
Acne

HEART
High Blood Pressure
Low Blood Pressure
Chest Pain
Ankle Swelling
Poor Circulation
Previous Stroke
Irregular Heartbeat
Blockage
Stents
Varicose Veins
Previous Heart Attack
POTS

NERVE
Weakness
Numbness
Tingling
Twitches
Tremors
Convulsions
Seizures
Facial Pain

WOMEN ONLY
Date of Last Menstrual Period _____
Date of Last Pap Smear _____
Name of Physician _____

MEN ONLY
Testicular Pain
Prostate Pain
Frequent Urination

EXERCISE/ACTIVENESS
1-3 times/wk
5-6 times/month
1-3 times/month
Never

Surgeries: _____

Allergies: _____

Medications: _____

_____

Who in your family has suffered from the following?
Ex: mom, dad, brother, sister
Heart Disease _____
Cancer_____
What type _____
Diabetes _____
High/Low Blood Pressure _____
Stroke _____
Thyroid _____

Do you smoke? Yes/No
If yes, how much/day? _____

Do you drink caffeine? Yes/No
If yes, how much/day? _____

Do you drink alcohol? Yes/No
If yes, how much/day? _____