**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_