Upper Cervical Care of SB[sm]

Personal Information Form

Date: _____

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Cell Phone: _____ Second Phone: _____

E-mail: (please print clearly) _____

Date of birth: _____ Age: ____ ❑ M ❑ F Occupation: _____

Marital Status: ❑ S ❑ M ❑ D Spouse s Name: _____ Occupation:_____

# of Children: ____ Name & age: _____

_____

How did you find us:_____

Symptoms and Present State of Health

Reason for Seeking Care in this Office:_____

_____

_____

Problem(s) started: _____

_____

What lessens your pain? What aggravates it?_____

_____

Is this condition progressively getting worse?_____

_____

Is this condition interfering with: ❑ Work ❑ Sleep ❑ Routine ❑ Whole Life

Other: _____

Do you have a family history of: ❑ Heart Disease ❑ Arthritis ❑ Cancer ❑ Diabetes

Other_____

Mark any of the following conditions / symptoms that you have now, or have experienced:

HAD	HAVE		HAD	HAVE		HAD	HAVE	
❑	❑	Headaches	❑	❑	Pain in Hands or Arms	❑	❑	Chest Pains
❑	❑	Neck Pain	❑	❑	Numbness Hands or Arms	❑	❑	Heart Attack
❑	❑	Sleeping Problems	❑	❑	Pain in Legs or Feet	❑	❑	High Blood Pressure
❑	❑	Low Back Pain	❑	❑	Numbness in Legs or Feet	❑	❑	Stroke
❑	❑	Nervousness	❑	❑	Fatigue	❑	❑	Cancer
❑	❑	Tension	❑	❑	Depression	❑	❑	Painful Urination
❑	❑	Irritability	❑	❑	Lights Bother Eyes	❑	❑	Diabetes
❑	❑	Dizziness	❑	❑	Loss of Memory	❑	❑	Diarrhea
❑	❑	Pain Between Shoulders	❑	❑	Shoulder Pain	❑	❑	Constipation
❑	❑	Neck Stiff	❑	❑	Sinus	❑	❑	Stomach Upset
❑	❑	Joint Swelling	❑	❑	Shortness of Breath	❑	❑	Heartburn/Reflux
❑	❑	Fever	❑	❑	Asthma	❑	❑	Sudden Weight Loss
❑	❑	Loss of Balance	❑	❑	Allergies	❑	❑	Loss of Smell or Taste
❑	❑	Ringing in Ears	❑	❑	Cold Hands	❑	❑	Menstrual Cramps
❑	❑	Jaw/TMJ Problems	❑	❑	Cold Feet	❑	❑	Menopause

Are you under medical care for any condition? _____

_____

What Medications are you taking? How long? _____

_____

Have you had surgery? When? Any side effects?_____

_____

Sports / Hobbies:_____

Anything else you wish me to know about you: _____

_____

_____

_____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature_____Date_____