Upper Cervical
Health Centers Of America

Confidential Patient Information

Name:_______________ □ Male □ Female Age:____ Date of Birth:__________
Home Phone:__________ Cell Phone:__________ Work Phone:__________
Address:__________ City:__________ State:______ Zip:______
E-mail:__________
Occupation:__________ Employer:__________
□ Married (Spouse's Name__________) □ Single □ Divorced □ Widowed
Whom may we thank for referring you? __________
Emergency Contact Person:__________ Phone Number:__________
Have you had Chiropractic care before? □ No □ Yes- When/Where?__________
If you are leaving area for extended periods, when are you leaving:__________ Returning:__________

HOW CAN WE SERVE YOU?

1. I have no complaints, I am here for a wellness check up. □

Subluxations (spinal misalignments) cause many of the unwanted health conditions people suffer from everyday. Subluxations affect your nervous system, which affects your health.

2. What is your first health concern?__________ First occurrence date:__________
Subluxations irritate nerve fibers causing various sensations. Which describes yours?
□ Sharp □ Dull □ Throbbing □ Burning □ Aching □ Stabbing □ Numbness □Other:__________
Depending on the type and degree of subluxation, nerve pressure can be constant or occasional. How often is yours concern? □ Constant □ Occasional

3. What is your second health concern?__________ First occurrence date:__________
Subluxations irritate nerve fibers causing various sensations. Which describes yours?
□ Sharp □ Dull □ Throbbing □ Burning □ Aching □ Stabbing □ Numbness
Depending on the type and degree of subluxation, nerve pressure can be constant or occasional. How often is your concern? □ Constant □ Occasional

Please list medications you are currently taking (prescriptions AND over the counter).
1.__________ 2.__________ 3.__________ 4.__________ 5.__________
Please list any/all surgeries: __________

Neurological
□ headaches
□ numbness, where?______
□ Irritable
□ nervousness
□ tremors
□ allergies
□ seizures
□ depression
□ fatigue
□ sleeping problems
□ unexplained weight loss
□ loss of balance
□ dizziness

Gastro Intestinal
□ diarrhea
□ constipation
□ colon trouble
□ loss of bowel control
□ difficult digestion
□ acid reflux
□ nausea/vomiting

Genito-Urinary
□ bed wetting
□ frequent urination
□ loss of urine control
□ kidney infection
□ prostate trouble
□ failing vision

Respiratory
□ asthma
□ chronic cough
□ sleep apnea

Do You Have
□ cancer
□ heart disease
□ diabetes

For Women Only
□ menstruation
□ infertility
□ Pregnant
Due Date ______

Cardio-Vascular
□ high blood pressure
□ low blood pressure
□ rapid heartbeat
□ slow heartbeat
□ swelling of the ankles
□ chest pain

Eyes, Ears, Nose & Throat
□ frequent cold
□ hearing loss
□ asthma
□ earaches
□ ringing in the ears
□ sinus infections
□ thyroid trouble

OFFICE USE ONLY
M W T TH F
TIME:

REF______
NPE ______
CERx ______
LBx______

OFFICE USE:
Medicare ______
In______
Other

Upper Cervical Health Centers
12651 McGregor Blvd., STE 102
Fort Myers, FL 33919
(239) 243-8810

PATIENTS'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health information, as a patient of this practice.

Affirmed,

____
Patient Name

____
Date

X-RAY CONSENT

During your examination, the doctor may feel that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patients consent for such tests.

I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests and x-rays.

Patient Signature *Date*

Witness *Date*

FEMALES ONLY:

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in anyway.

Patient Signature *Date*

Witness *Date*