

**Licata**  
CHIROPRACTIC, INC.  
NUCCA Spinal Care

**Practice Member Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

Street City State Zip Code  
**E-mail** \_\_\_\_\_ (Office correspondence will be made primarily via E-mail.)

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Single\_\_ Married \_\_ Name of Spouse: \_\_\_\_\_ No. of children: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**Who may we thank for referring you to our office?**

\_\_\_\_\_

**Please check all who are presently receiving Upper Cervical Care:**

( ) Husband/Wife ( ) Children ( 1 2 3 4 5 )  
( ) Mother/Father ( ) Siblings ( 1 2 3 4 5 ) ( ) Other Family Member ( 1 2 3 4 5 )  
( ) Neighbor ( ) Co-worker ( 1 2 3 4 5 ) ( ) Other Friend or Acquaintance ( 1 2 3 4 5 )

**Had you learned about Upper Cervical Care through:**

Drlicata.com	yes/ no	Introduction to NUCCA DVD	yes/ no
licataclinic.com	yes/ no	The Power of Upper Cervical DVD	yes/ no
“Good Morning America”	yes/ no	Discovery Health Channel	yes/ no

**A. What is your Primary Health Concern today?**

\_\_\_\_\_

**B. Name/Address of the last Doctor who put you on a health development program?**

\_\_\_\_\_

-Were you able to stay on the program? \_\_\_\_\_ How Long? \_\_\_\_\_

-What were your results? \_\_\_\_\_ Were your results permanent? \_\_\_\_\_

**C. Are you healthier today than you were 5 years ago? Yes/ No**

-If so, what did you do to improve your health? \_\_\_\_\_

-If not, why do you think your health declined? \_\_\_\_\_

**D. Will you be healthier 5 years from now than you are today? Yes/ No**

-If so, what are you planning to do to improve your health? \_\_\_\_\_

-If not, what could you do to improve your health rather than have it continue to decline? \_\_\_\_\_

\_\_\_\_\_

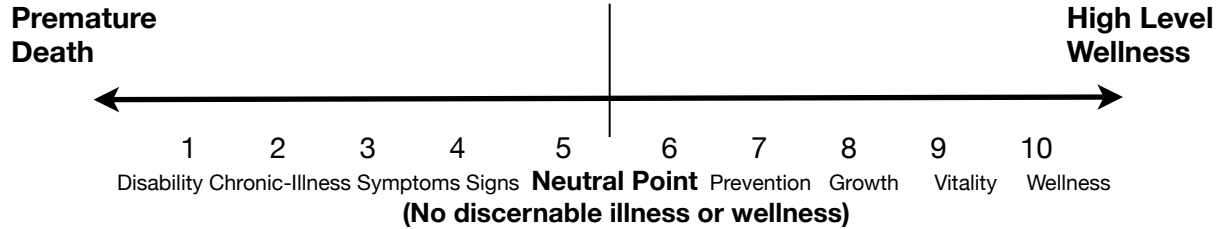
**E. What would you like your health to be 5 years from now?** \_\_\_\_\_

\_\_\_\_\_

## Confidential Health Information

Practice Member Name \_\_\_\_\_

A. Please circle your level of health Now on a scale of 1-10:



B. Which level of health are you seeking to obtain? (1-10) \_\_\_\_\_

C. What are your long-term health objectives in consulting our office?

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

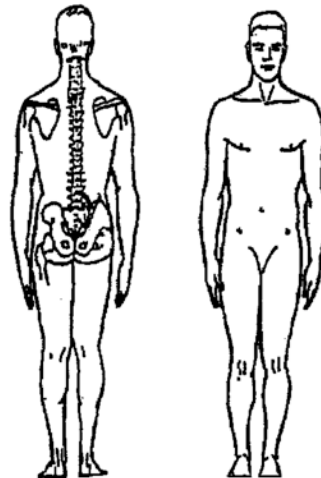
D. Reason for Seeking Upper Cervical Care:

Neurological Health:

- ( ) 1. Sensation and Feeling
- ( ) 2. Voluntary & Involuntary Movement
- ( ) 3. Cognitive and Emotional Function
- ( ) 4. Global Organ System Regulation

Structural Health:

- ( ) 1. Spine and Discs
- ( ) 2. Muscles and Joints
- ( ) 3. Shoulders, Arms, Hands
- ( ) 4. Pelvis, Hips, Legs, Feet



E. History of Trauma or Accidents (By Date)

- ( ) Difficult Birth \_\_\_\_\_
- ( ) Childhood Falls/Accidents \_\_\_\_\_
- ( ) Sports Traumas \_\_\_\_\_
- ( ) Slips/Falls \_\_\_\_\_
- ( ) Car Accidents \_\_\_\_\_
- ( ) Other \_\_\_\_\_

## Confidential Health History

**O – OCCASIONAL**  
**F – FREQUENT**  
**C – CONSTANT**

**O F C**

**GENERAL**

- |                                     |                                     |                                     |                    |
|-------------------------------------|-------------------------------------|-------------------------------------|--------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Allergy            |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Stroke             |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Convulsions        |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Dizziness          |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Fainting           |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Fatigue            |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Fever              |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Headache           |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Loss of sleep      |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Loss of weight     |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Nervous/depression |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Neuralgia          |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Numbness           |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Cancer             |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Tremors            |

**MUSCLE & JOINT**

- |                                     |                                     |                                     |                        |
|-------------------------------------|-------------------------------------|-------------------------------------|------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Arthritis              |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Bursitis               |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Foot trouble           |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hernia                 |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Low back pain          |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Lumbago                |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Neck pain or stiffness |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Pain between shoulder  |
|                                     |                                     |                                     | Pain or numbness in:   |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Shoulders              |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Arms                   |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Elbows                 |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hands                  |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hips                   |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Legs                   |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Knees                  |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Feet                   |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Painful tail bone      |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Poor posture           |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Sciatica               |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Spinal Curvature       |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Swollen joints         |

**O F C**

**GASTRO-INTESTINAL**

- |                                     |                                     |                                     |                       |
|-------------------------------------|-------------------------------------|-------------------------------------|-----------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Belching or gas       |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Colitis               |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Colon trouble         |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Constipation          |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Diarrhea              |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Difficult digestion   |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Distension of abdomen |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Excessive hunger      |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Gall bladder trouble  |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hemorrhoids           |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Intestinal worms      |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Jaundice              |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Liver trouble         |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Nausea                |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Pain over stomach     |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Poor appetite         |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Vomiting              |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Vomiting of blood     |

**EYES, EARS, NOSE & THROAT**

- |                                     |                                     |                                     |                   |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Asthma            |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Colds             |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Crossed eyes      |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Deafness          |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Dental Decay      |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Earache           |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Ear discharge     |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Ear noises        |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Enlarged glands   |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Enlarged thyroid  |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Eye pain          |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Failing vision    |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Far sightedness   |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Gum trouble       |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hay fever         |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hoarseness        |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Nasal obstruction |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Near sightedness  |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Nosebleeds        |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Sinus infection   |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Sore throat       |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Tonsillitis       |

**O F C**

**CARDIO-VASCULAR**

- |                                     |                                     |                                     |                       |
|-------------------------------------|-------------------------------------|-------------------------------------|-----------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hardening of arteries |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | High blood pressure   |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Low blood pressure    |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Pain over heart       |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Poor circulation      |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Rapid heart beat      |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Slow heart beat       |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Swelling of ankles    |

**RESPIRATORY**

- |                                     |                                     |                                     |                     |
|-------------------------------------|-------------------------------------|-------------------------------------|---------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Chest pain          |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Chronic cough       |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Difficult breathing |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Spitting up blood   |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Spitting up phlegm  |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Wheezing            |

**SKIN**

- |                                     |                                     |                                     |                       |
|-------------------------------------|-------------------------------------|-------------------------------------|-----------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Boils                 |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Bruise easily         |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Dryness               |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hives or allergy      |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Itching               |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Skin eruptions (rash) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Varicose veins        |

**GENITO-URINARY**

- |                                     |                                     |                                     |                      |
|-------------------------------------|-------------------------------------|-------------------------------------|----------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Bed-wetting          |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Blood in urine       |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Frequent urination   |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Inability to control |

kidneys

- |                                     |                                     |                                     |                            |
|-------------------------------------|-------------------------------------|-------------------------------------|----------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Kidney infection or stones |
|-------------------------------------|-------------------------------------|-------------------------------------|----------------------------|

- |                                     |                                     |                                     |                   |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Painful urination |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------|

- |                                     |                                     |                                     |                  |
|-------------------------------------|-------------------------------------|-------------------------------------|------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Prostate trouble |
|-------------------------------------|-------------------------------------|-------------------------------------|------------------|

- |                                     |                                     |                                     |              |
|-------------------------------------|-------------------------------------|-------------------------------------|--------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Pus in urine |
|-------------------------------------|-------------------------------------|-------------------------------------|--------------|

**FOR WOMEN ONLY**

- |                                     |                                     |                                     |                   |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Congested breasts |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------|

- |                                     |                                     |                                     |                    |
|-------------------------------------|-------------------------------------|-------------------------------------|--------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Cramps or backache |
|-------------------------------------|-------------------------------------|-------------------------------------|--------------------|

- |                                     |                                     |                                     |                     |
|-------------------------------------|-------------------------------------|-------------------------------------|---------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Excessive menstrual |
|-------------------------------------|-------------------------------------|-------------------------------------|---------------------|

flow

- |                                     |                                     |                                     |             |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hot flashes |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------|

- |                                     |                                     |                                     |                 |
|-------------------------------------|-------------------------------------|-------------------------------------|-----------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Irregular cycle |
|-------------------------------------|-------------------------------------|-------------------------------------|-----------------|

- |                                     |                                     |                                     |                     |
|-------------------------------------|-------------------------------------|-------------------------------------|---------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Menopausal symptoms |
|-------------------------------------|-------------------------------------|-------------------------------------|---------------------|

- |                                     |                                     |                                     |                      |
|-------------------------------------|-------------------------------------|-------------------------------------|----------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Painful menstruation |
|-------------------------------------|-------------------------------------|-------------------------------------|----------------------|

- |                                     |                                     |                                     |                   |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Vaginal discharge |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------|

- |                                     |     |                                     |    |         |
|-------------------------------------|-----|-------------------------------------|----|---------|
| <input checked="" type="checkbox"/> | Yes | <input checked="" type="checkbox"/> | No | Are you |
|-------------------------------------|-----|-------------------------------------|----|---------|

pregnant?