NEURAPERFORMANCE
BRAIN CENTER

Patient Name:_____
Patient Date Of Birth: ____/____/_____

Welcome to NeuraPerformance Brain Center! Carefully complete all of the following health history questionnaires. The accuracy of your answers will help us better diagnose and treat your condition. Thank you for your patience with what may appear to be some duplication in questions in different areas. Each questionnaire has been carefully designed to identify your specific condition.

Patient Name:_____ D.O.B. : _____
How old are you?_____ Handed: ☐ Right ☐ Left ☐ Ambidextrous ☐ Male ☐ Female SSN:_____-_____-____
Street Address: _____ Unit/Apt._____
City: _____ State: _____ ZIP: _____
Phone: (_____) _____ ☐ Home ☐ Mobile Alternate Phone: (_____) _____
E-mail address: _____ Preferred: ☐ Cell ☐ Home ☐ Text ☐ Email

Primary Physician:

Street Address: _____ City:_____ State: _____ ZIP:_____
Name:_____ Effective Date: _____

Primary Mental Health Provider:

Street Address: _____ City:_____ State: _____ ZIP:_____
Name:_____ Effective Date: _____

Insurance Information:

Primary Insurance:_____
Insurance cert #:_____ Plan Type:_____Group #: _____
Guarantor/Member's Name:_____ Guarantor SSN: _____-_____-_____
Guarantor's Relationship to Patient: ☐ Husband ☐ Wife ☐ Parent Date of Birth:_____

Primary Pharmacy:

Street Address: _____ City:_____ State: _____ ZIP:_____
Name:_____ Effective Date: _____

Emergency Contact Information:

Contact Name:_____
Phone: (_____) _____ ☐ Home ☐ Mobile Alternate phone: (_____) _____
Relationship to Patient:_____

How did you hear about us?_____

_____
_____

Did a physician refer you? ☐ Yes ☐ No
Physician Name: _____ Physician Address: _____
City: _____ State:_____ ZIP: _____ Telephone #: (_____) _____

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Patient Name:_____
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Check as many that apply to you about your reason for visiting us today:

- ☐ Headaches
- ☐ Balance Issues
- ☐ Medication Management
- ☐ Sports Improvement
- ☐ Head Injury
- ☐ Neurological Assessment
- ☐ Sleeplessness
- ☐ Nutritional Counseling
- ☐ Other: _____

If injury occurred, when? _____/_____/_____ Describe: _____

_____

Another type of accident, trauma, or injury

_____

Neurological problem or disease: please explain and include prior diagnosis

_____

Diagnostics: please list previous diagnostic tests given for current complaints:

_____

Causes of your pain symptoms

Event(s) surrounding the onset of symptoms	Date	Pain Intensity Today
		☐Better ☐ Same ☐Worse
		☐Better ☐ Same ☐Worse
		☐Better ☐ Same ☐Worse

Medication List

☐ Patient taking non-medications regularly and none in the past 72 hours.

MEDICATIONS (INCLUDE OVER-THE—COUNTER AND HERBAL MEDICATIONS.)	DOSE (e.g., strength, # of pills or drops)	ROUTE (e.g., by mouth, etc.)	FREQUENCY (how often)
Example: Vitamin C	250 mg	By mouth	Once a day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Known Food, Drug, or Environmental Allergies: _____

_____

_____

_____.

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What are your three main goals for treatment?

What are you hoping to gain from your visit to NPBC?

1)_____
2)_____
3)_____

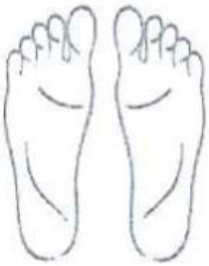
Brain Health Rank: *How well do you think your brain is functioning?*

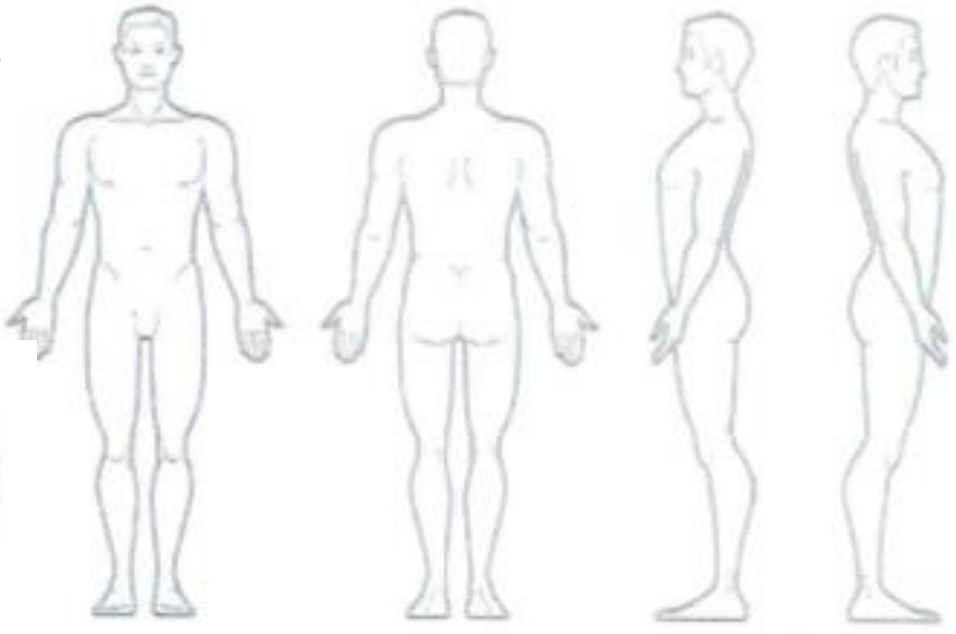
Terribly 1 2 3 4 5 6 7 8 9 10 Great

Have you seen anyone else for this condition? ☐ No ☐ Yes, If yes, who?_____
Have you lost work days because of this condition? ☐ No ☐ Yes. If yes, how many?
How long has this problem been present? ☐ Weeks_____ ☐ Months_____ ☐ Years_____
What do you think is causing your present condition? _____
Indicate any other symptoms you think may be important: _____
What are you 3 greatest concerns about your present state of health?
1._____. 2._____.3._____

On the diagram, please mark the following symptoms, if you are experiencing them:

"//" Stabbing Pain
"B" Burning Pain
"D" Dull Pain
"N" On or In areas where you have numbness
"A" Aching Pain
"T" Tingling
"St" Stiffness
"Sw" Swelling
"C" Cramps
"Tr" Tremor
"W" Weakness





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Patient Name:_____
Patient Date Of Birth: ____/____/_____

Doctor's Notes: _____

_____

_____Doctor Initials:_____

Personal Health History

Please answer the following questions as completely as possible.

Do you have a:

Pacemaker ☐ No ☐ Yes. Explain_____

Artificial Joint ☐ No ☐ Yes. Explain_____

Artificial Heart Valve ☐ No ☐ Yes. Explain_____

Stent ☐ No ☐ Yes. Explain_____

List all operations and surgeries you may have had, with dates (month/year). _____

_____

_____.

List any major illnesses you have had, with dates (month/year). _____

_____

_____.

Have you had any recent infections (colds or flue?) ☐ No ☐ Yes. When? _____

Have you suffered a head injury or Concussion? Did you lose consciousness? How long?). _____

_____

_____.

Have you ever been diagnosed with a tumor, cancer, or neoplasia? ☐ No ☐ Yes. When?_____

Have you ever been diagnosed with diabetes? ☐ No ☐ Yes. When?_____

Have you ever been diagnosed with a cardiac (heart) condition, a blood vessel condition (like arteriosclerosis, atherosclerosis, or vasculitis), or hypertension (high blood pressure.) ☐ No ☐ Yes. When?_____

Have you ever had a stroke or heart attack? ☐ No ☐ Yes. When?_____

Have you ever had a spinal cord injury? ☐ No ☐ Yes. When?_____

Have you ever had surgery on your neck? ☐ No ☐ Yes. When?_____

Does anyone in your biological family (parent, grandparent, sibling, or child) have a history of:

Heart disease, stroke, cancer or diabetes? ☐ No ☐ Yes. When?_____

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Psychiatric diseases like depression, anxiety, schizophrenia, etc. ☐ No ☐ Yes. When?_____
Neuropathies (nerve disease) or myopathies (muscle disease)? ☐ No ☐ Yes. When?_____
Cancer? ☐ No ☐ Yes. When?_____
Back of Neck Pain? ☐ No ☐ Yes. When?_____
Any other known conditions? ☐ No ☐ Yes. When?_____

The following questions help us determine levels of stress. Please answer as completely as possible.

Please indicate your marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed
How many children do you have? ☐ None ☐ 2 ☐ 3 ☐ Other: _____
Do you have a second job:_____ How many hours a week?_____
Describe your work environment: _____
Describe your home life:_____
What is your highest level of education?: _____
What are your hobbies: _____

Please answer the following questions as completely as possible. (Social history)

Quality of Life Rank. *Please circle where you rate your current quality of life.*

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Has your quality of life changed? ☐ No ☐ Yes. Explain?_____
Do you exercise? ☐ No ☐ Yes. What type and how often?_____
Do you currently use any tobacco products? ☐ No ☐ Yes.
What kind, how often, and how long?_____
Have you used tobacco products in the past? ☐ No ☐ Yes.
What kind, how often, and how long?_____
Do you drink alcoholic beverages? ☐ No ☐ Yes. What type and how often?_____
Have you had issues with alcohol in the past? ☐ No ☐ Yes.
How long ago and for how long?_____
Do you drink caffeinated beverages? ☐ No ☐ Yes. What type and how often?_____
Do you currently use recreational drugs? ☐ No ☐ Yes. What type and how often?_____
Have you used recreational drugs in the past? ☐ No ☐ Yes. What type and how long?_____
Do you have any special dietary restrictions? ☐ No ☐ Yes. What type?_____
Are you sexually active? ☐ No ☐ Yes. Have you ever been diagnosed with an STD or VD? ☐ No ☐ Yes
Do you currently see a chiropractor? ☐ No ☐ Yes. When did you last see a chiropractor?_____

Quality of Sleep. *Please circle where you rate your current quality of Sleep.*

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Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Can you fall asleep? ☐ No ☐ Yes. How long?_____
Nightmares/Vivid dreams? ☐ No ☐ Yes.
Are you able to stay asleep? ☐ No ☐ Yes.
Night sweats? ☐ No ☐ Yes.
Restless leg at night? ☐ No ☐ Yes.

Headache. *Please rate your headaches on a scale of one to ten.*

No Pain 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

Where do you feel the head pain? _____

Does the pain start at the neck and go up? _____

Have you identified triggers? ☐ No ☐ Yes. How many triggers per month? _____

What aggravates the headache? _____

What makes it better? _____

Quality of Headache? ☐ Dull ☐ Fast ☐ Throbbing

Review of Systems and Medical History

1. Does anything trigger your symptoms such as ☐ exercise ☐ sleep ☐ posture ☐ environment?

2. Do your symptoms get worse with physical or mental activity? ☐ No ☐ Yes._____

3. Are you currently experiencing any of the following symptoms, now or recently?

☐ Chest Pain	☐ Loss of skin color	☐ Neck Pain	☐ Shortness of breath
☐ Light headedness	☐ Swelling in your left arm	☐ Blackouts	☐ Left arm pain
☐ Jaw pain	☐ Excessive sweating without exertion		

5. Please check off any of the below symptoms that you are experiencing now or recently.

☐ Nausea	☐ Difficulty Swallowing	☐ Balance Problems	☐ Headache
☐ Vomiting	☐ Difficulty Speaking	☐ Diziness or Vertigo	☐ Unsteady Feeling
☐ Blurred Vision	☐ Double Vision	☐ Numbness	

6. Have you noticed any of the following?

☐ Recent Fever	☐ Brain Fog	☐ Memory Issues	☐ Unexplained weight loss
☐ Drowsiness	☐ Sensitivity to Sound	☐ Confusion	☐ Change in Appetite

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☐ Pressure in head ☐ Sensitivity to Light ☐ Recent fatigue ☐ Unexplained weight gain

☐ More Emotional

Osteroporosis	☐ ☐	Blurred vision	☐ ☐	Panic attacks	☐ ☐
Dislocated Bones	☐ ☐	Double vision	☐ ☐	PTSD	☐ ☐
Fractured Bones	☐ ☐	Muscle Cramping	☐ ☐	OCD	☐ ☐
Bone Infection (osteomyelitis)	☐ ☐	Tremors (shaking)	☐ ☐	Kidney problems or disease	☐ ☐
Herniated Disc	☐ ☐	Dyslexia	☐ ☐	Difficulty urinating	☐ ☐
Scoliosis or other Curvature	☐ ☐	Sleep apnea	☐ ☐	Feelings of urgency when urinating	☐ ☐
Osteoarthritis or DJD	☐ ☐	Cataracts	☐ ☐	Leg pain with walking	☐ ☐
Rheumatoid Arthritis	☐ ☐	Arythm,ia	☐ ☐	Blood clots/ohlebitis	☐ ☐
Other Arthritis	☐ ☐	Heart Murmur	☐ ☐	Frequent colds or flues	☐ ☐
Gout	☐ ☐	Atherosclerosis or arteriosclerosis	☐ ☐	Alcoholism	☐ ☐
Mental or Emotional Disorder	☐ ☐	Wheezing	☐ ☐	Cancer	☐ ☐
Learning Disability	☐ ☐	Asthma	☐ ☐	Feeling suicidal	☐ ☐
Glaucoma	☐ ☐	Gastric Ulcers	☐ ☐	Infrequent urination	☐ ☐
Heart Palpitations	☐ ☐	Celiac Disease (Sprue)	☐ ☐	Blood in urine	☐ ☐
Swelling in legs or feet	☐ ☐	Irritable Bow Syndrome	☐ ☐	Painful urination	☐ ☐
Congestive Heart Failure	☐ ☐	Night sweats	☐ ☐	Awaken to urinate	☐ ☐
Chronic/ Frequent cough	☐ ☐	Psoriasis	☐ ☐	Bladder infections	☐ ☐
COPD	☐ ☐	Skin cancer	☐ ☐	Venous insufficiency	☐ ☐
Coughing up blood	☐ ☐	Loss of consciousness	☐ ☐	HIV/AIDS	☐ ☐
Colon Problems	☐ ☐	Concussions	☐ ☐	Other (*please describe):* _____	☐ ☐
Gall bladder trouble	☐ ☐	Weak muscles of face	☐ ☐	_____	
Liver Disease	☐ ☐	Bed wetting	☐ ☐	_____	
Stomach/duodenal ulcer	☐ ☐	Retinopathy	☐ ☐	_____	
Cirrhosis	☐ ☐	High cholesterol	☐ ☐	_____	
Change in hat size	☐ ☐	Scarlet fever	☐ ☐	_____	
Acne	☐ ☐	Rheumatic fever	☐ ☐	_____	
Hypertension	☐ ☐	Emphysema	☐ ☐	_____	
Seizures	☐ ☐	Bronchitis	☐ ☐	_____	
Trouble Concentrating	☐ ☐	Hepatitis	☐ ☐	_____	
Paralysis	☐ ☐	Chrohn's disease	☐ ☐	_____	
Twitching Muscles	☐ ☐	Diabetes	☐ ☐	_____	
ADD or ADHD	☐ ☐	Hyperthyroidism	☐ ☐	_____	
Macular Degeneration	☐ ☐	Hypothyroidism	☐ ☐	_____	
Ringing in ears	☐ ☐	Shingles	☐ ☐	_____	
Sinus problems	☐ ☐	Herpes	☐ ☐	_____	
Mouth sores	☐ ☐	Warts	☐ ☐		
Irregular heart beats	☐ ☐	Psychological issues	☐ ☐		

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Experience passing out	☐ ☐	Depression	☐ ☐
Skipped Heart beats	☐ ☐	Prostate problems	☐ ☐
Congenital heart disease	☐ ☐	Erectile Dysfunction	☐ ☐
Shortness of breath exercising	☐ ☐	Discharge from urethra	☐ ☐
Shortness of breath resting	☐ ☐	Bleeding disorder	☐ ☐
Polyps	☐ ☐	Anema	☐ ☐
Diverticulitis	☐ ☐	Anxiety	☐ ☐
Change in nails	☐ ☐	Phobias	☐ ☐
Eczema	☐ ☐	Breast discharge	☐ ☐
Dermatitis	☐ ☐	Breast lumps/soreness	☐ ☐
Pain in your face	☐ ☐	Vascular Disease	☐ ☐
Temporal Arteritis	☐ ☐	Varicose veins	☐ ☐
Fainting Spells	☐ ☐	Auto immune disorder	☐ ☐