NEURO SERVICES HEALTH™

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Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Patient and Contact Information

Patient Name_____ **Today's Date** _____

Address _____ **City** _____

State _____ **ZIP** _____ **Social Security #** _____

Gender: ❑ Male ❑ Female **Height** _____ **Weight** _____ **Date of Birth** _____

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

Home Phone (_____) _____ **Cell** (_____) _____

Work Phone (_____) _____ **Email** _____

Contact you via: ❑ Home ❑ Cell ❑ Work ❑ Email ❑ Text

(appointment confirmations only) **Cell phone provider** _____

Occupation _____ **Employer/School** _____

Spouse/Partners Name _____ **Employer** _____

Spouse/Partners Work Phone (_____) _____ **Cell** (_____) _____

Emergency Contact name _____ **Relationship** _____

Emergency Contact cell phone (_____) _____ **Work phone** (_____) _____

List of current/previous doctors (If applicable):

Primary Care Physician _____

Primary Care Physician Office Phone (_____) _____

Medical Neurologist _____

Medical Neurologist Office Phone (_____) _____

Endocrinologist _____

Endocrinologist Office Phone (_____) _____

Rheumatologist _____

Rheumatologist Office Phone (_____) _____

Surgeon _____

Surgeon Office Phone (_____) _____

How did you choose our office? (e.g. Referral, internet, advertisement, etc.)

_____

CHRONIC NEUROLOGICAL & METABOLIC CASE HISTORY

What is the main problem/symptom that you are having? (Be as specific as possible)

_____

_____

When did this begin? _____ **How did this begin?** _____

Have you had this or similar conditions in the past? ❑ Yes ❑ No
If yes, when? _____

What aggravates your condition? _____

What makes it better? _____

Describe what you are feeling? _____

Do you experience Numbness or Tingling? ❑ Yes ❑ No
If yes, where? _____

SYMPTOM INTENSITY: Please circle the number describing the intensity of symptoms.

None —> 0 1 2 3 4 5 6 7 8 9 10 <— Unbearable

When you are awake, how often are you feeling these symptoms? (0 – 100%) _____**%**

Is this progressively getting worse? ❑ Yes ❑ No

Is your condition: ❑ Constant ❑ Comes & goes

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily routine
❑ Other _____

Has there been any medical diagnosis of your complaint: ❑ Yes ❑ No
If yes, please list doctor's name and diagnosis: _____

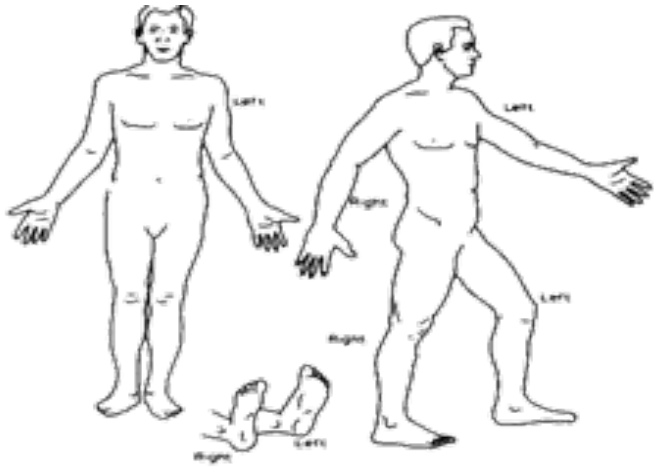
How have you tried to take care of this problem in the past? <u>Circle all that apply</u>
Medications Emergency room Surgery Routine Medical Exercise Supplements
Regular Chiropractic Other (specify) _____

How did the previous method(s) work out for you? <u>Circle all that apply</u>
Bad results Some results Great results Nothing changed
Didn't get worse Didn't work very long

What are you afraid this might be?_____

Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the diagram to accurately describe your problem.

PPP	PAIN
WWW	WEAKNESS
NNN	NUMBNESS
HHH	HEAT
TTT	TINGLING
BBB	BURNING
CCC	CRAMPING
FFF	STIFFNESS



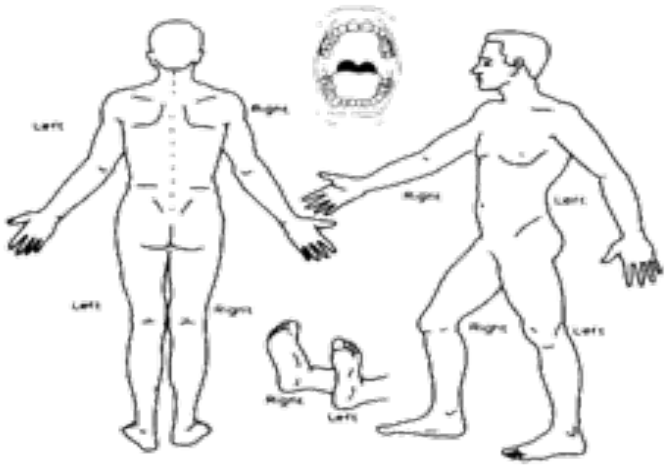
Does the symptom radiate? ❑ Yes ❑ No

If yes, where and how frequently

_____

_____

_____



How long/often does the radiation last/occur?

_____

_____

_____

Are there any conditions that run in your family? ❑ Yes ❑ No
If yes, what condition(s) and what family member?

_____

When was your last: Physical _____ **Blood/lab work** _____ **X-ray study** _____

Have you been treated for your current condition before? ❑ Yes ❑ No
If yes, when/by whom? _____

Please list any natural supplements you're currently take and for what conditions:

_____

_____

Surgical History: Please list the type and reason of surgery, and year performed (e.g. left breast for cancer in 2004) _____

Medication List: Please list the name of each current prescribed and over the counter medications, it's prescribed use and any side effects/reactions/positive responses (example of use: BCP – birth control pills used to prevent pregnancy, manage menopause or acne, etc.; example of side-effect: Tylenol caused liver enzymes to increase)

	Medication	Name of Condition or purpose for taking med	Any side-effects
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Other Medical or Physical conditions: Please check all that apply

❑ ADD/ADHD
❑ Adrenal gland disorder
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Autoimmune disease:
_____
❑ Bladder issue
❑ Bleeding disorder
❑ Blurred vision
❑ Buzzing/Ringing in ear
❑ Cancer – type?
_____
❑ Carpal Tunnel Synd.
❑ Celiac disease
(gluten sensitive)
❑ Chest pains
❑ Chronic fatigue
❑ Cold hands or feet
❑ Colitis/Diverticulitis
❑ Compression fractures
❑ Concussion
❑ COPD
❑ Dementia/Memory Loss
❑ Depression
❑ Diabetes (Type 1 /2)
❑ Digestive/bowel issues
❑ Dizziness or vertigo
❑ Dyslexia
❑ Ear infections
❑ Fibromyalgia
❑ Food sensitivity
❑ Fusions (spinal, joint)
❑ Gall Bladder issue
❑ Gout
❑ Hashimoto's thyroiditis
❑ Heart disease
❑ Hepatitis A, B, C, etc.
❑ Herpes
❑ High blood pressure
❑ Hip replacement
❑ HIV/AIDS
❑ Immune deficiency
❑ Insomnia
❑ Kidney disease
❑ Knee surgery
❑ Leaky Gut Syndrome
❑ Light/Sound sensitivity
❑ Liver disease
❑ Marfan's syndrome
❑ Motion sickness
❑ Multiple Sclerosis
❑ Osteoporosis/penia
❑ Parkinson's disease
❑ Rotator cuff problem
❑ Shoulder surgery
❑ Spinal surgery
❑ STI/STD
❑ Stroke/TIA
❑ Thyroid problems
❑ Traumatic Brain Injury
❑ Tuberculosis
❑ Other
_____
❑ Other
_____