NEUROSPORT
ELITE

Name:_____ **Date of Birth:**_____

Primary Reason for Visit:

What is the primary reason you are here today?

_____

How long has this problem been present? □ Weeks □ Months □ Years

Is there anything that makes your condition worse?

_____

Is there anything that makes your condition better?

_____

What do you think is causing your present condition?

_____

Indicate anything you think may be important.

_____

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?_____

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:_____

_____

Does anything trigger your symptoms? □ Exercise □ Sleep □ Posture □ Environment

Do your symptoms get worse with physical or mental activity? □ No □ Yes

What are your three greatest concerns about your present state of health?

_____

What are you hoping to gain from your visit to NeuroSport Elite? _____

_____

Check % relief or increase in function you feel would make treatment worthwhile:

□ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

Brain Health Rank:

How well do you think your brain is functioning?

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

Quality of Sleep:

Please circle where you rate your current quality of life.

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

Do you have trouble falling asleep? □ No □ Yes

If yes, how long does it typically take for you to fall asleep?_____

Nightmares/Vivid dreams? □ No □ Yes

Are you able to stay asleep? □ No □ Yes

How many times do you wake up?_____

Night sweats? □ No □ Yes

Restless leg at night? □ No □ Yes

NEUROSPORT
ELITE

Headache:

Please circle where you rate your current quality of life.

No Pain □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 Worst Pain Ever

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 times per month?_____

What aggravates the headache?_____

What makes it better?_____

Quality of Headache? □ Dull □ Fast □ Throbbing

Does anything trigger your symptoms: □ exercise □ sleep □ posture □ environment Anything else?_____

Do your symptoms get worse with physical or mental activity? □ No □ Yes

Are there any other concerns or interests you have about your health that you would like us to address?

_____

Past Medical History:

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

_____

_____

_____

_____

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

_____

_____

_____

_____

Do you have any allergies (environmental, food, drug, latex)? □No □Yes

Have you had any recent infections, colds, or flu? □ No □ Yes When?_____

Have you ever suffered a Head injury or Concussion? □ No □ Yes

Did you lose consciousness? □ No □ Yes How long?_____

Do you currently see a chiropractor? □ No □ Yes

When did you last see a chiropractor?_____ Who?_____

Family Health History:

Does anyone in your biological family (parent, grandparent, sibling, or child) have a history of heart disease, cancer, stroke, cancer or diabetes? □ No □ Yes

If yes, indicate which disease and their relationship to you._____

Does anyone in your biological family have a history of psychiatric disease (depression, anxiety, schizophrenia, etc)? □ No □ Yes

If yes, indicate which disease and their relationship to you._____

Neuropathies (nerve disease) or myopathies (muscle disease)? □ No □ Yes

If yes, indicate which disease and their relationship to you._____

Back or neck pain? □ No □ Yes

If yes, indicate which disease and their relationship to you._____

Any other known conditions?□ No □ Yes

If yes, indicate which disease and their relationship to you._____

Social History:

Familial status: □ Single □ Married □ Divorced □ Widowed □ Partnered
How many children do you have? □ None □ 1 □ 2 □ 3 □ 4 □ Other:_____
Do you have multiple jobs? □ No □ Yes How many hours per week?_____ Describe your work environment:_____
Describe your home life:_____
What is your highest level of education?_____
What are your hobbies?_____

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 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 long, and when did you quit?_____
Do you drink alcoholic beverages? □ No □ Yes
What kind and how many a week?_____
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 kind and how many a day?_____
Do you currently use recreational drugs? □ No □ Yes
What type, how often, and how long?_____
Have you used recreational drugs in the past? □ No □ Yes
What kind, how long, and for how long?_____
Do you have any special dietary restrictions? □ No □ Yes What type?_____
How many times a week do you eat raw nuts or seeds?_____
How many times a week do you eat fish?_____
Are you sexually active? □ No □ Yes
Have you ever been diagnosed with an STD or VD? □ No □ Yes

Patient Authorization:

Thank you for taking the time to fill out this health history questionnaire. This information is important to the doctor obtaining an accurate clinical picture so as to make an appropriate diagnosis and treatment plan. Please sign below authorizing that the information in this form has been read and filled out completely and accurately to the best of your understanding. Also, understand that the information in this form is considered confidential and for use by your doctor at NeuroSport Elite.

Any disclosure is outlined in our privacy policies.

Patient (or guardian) signature:_____ Date:_____

Printed name:_____

Signature of translator or person assisting you:_____ Date:_____