Bagnell BRAIN CENTER™

Welcome to the Bagnell 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: _____ **DOB:** _____

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

✓ **Emergency Contact Information:** **Contact Name:** _____

Phone: (____)_____ ❑Home ❑Mobile **Alternate phone:** (____)_____

Relationship to Patient: _____

✓ **Insurance Information:** As a courtesy to you, we will consider what possible insurance benefits you may have under your policy.

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:** _____

✓ **Primary Mental Health Provider:** **Street address:** _____ **City:** _____ **State:** _____ **ZIP:** _____

Name: _____ **Effective Date:** _____

✓ **Primary Physician:** **Street address:** _____ **City:** _____ **State:** _____ **ZIP:** _____

Name: _____ **Effective Date:** _____

✓ **How did you hear about us?** _____

Did a physician refer you? ❑ Yes ❑ No

Physician Name: _____ **Physician Address:** _____

City: _____ **State:** _____ **ZIP:** _____ **Telephone Number:** (____)_____

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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 & include any prior diagnoses:

❑ 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 nonmedications 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, # inhaled, on skin)	FREQUENCY (how often)
Example: Vitamin C	*250 mg*	*By mouth*	*Once a day*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Known Food Drug on Environmental Allergies

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✓ Patient Name: _____

Date of Birth: _____/_____/_____

✓ What is the most important thing we can do for you? _____

_____

_____

✓ Expectations.

What are you hoping to gain from your visit to BBC? Circle % 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

✓ 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? _____

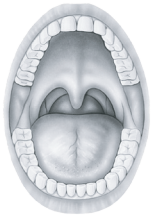
✓ Indicate any other symptoms you think may be important. _____

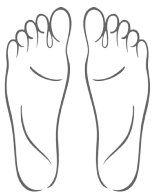
✓ What are your 3 greatest concerns about your present state of health?

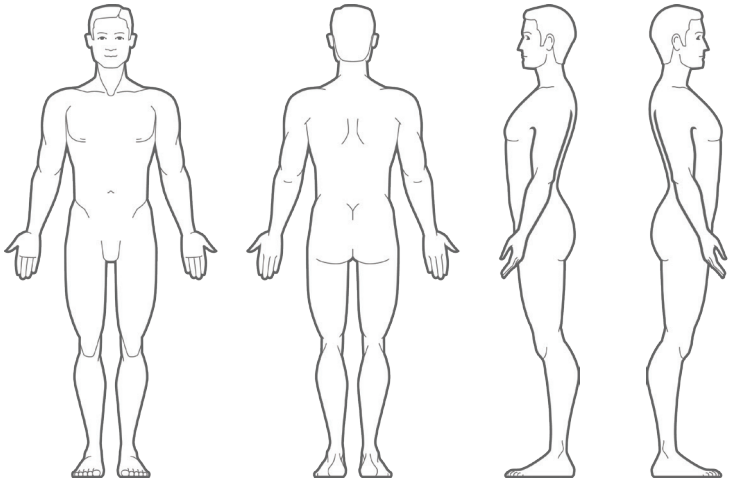
1. _____ 2. _____ 3. _____

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

"//"	stabbing pain
"B"	for burning pain
"D"	for dull pain
"A"	for aching pain
"N"	on or in areas where you have numbness
"T"	in areas where you have tingling
"St"	in areas where you feel stiffness
"Sw"	in areas where you've had swelling
"C"	In areas where you have cramps
"W"	for weakness
"Tr"	for tremor







— **Doctor's Notes.** _____

_____

_____ Doctor's initials: ____

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✓ Patient Name: _____

Date of Birth: _____/_____/_____

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 illness you have had, with dates *(month/year)* _____

_____

_____

Have you had any recent infections, colds, or flu? ❑No ❑Yes. When? _____/_____/_____

Have you suffered a Head Injury or Concussion? Did you lose conciousness? 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 surgury 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. Explain _____

Psychiatric diseases like depression, anxiety, schizophrenia, etc? ❑No ❑Yes. Explain _____

Neuropathies (nerve disease) or myopathies (muscle disease)? ❑No ❑Yes. Explain _____

Cancer? ❑No ❑Yes. Explain _____

Back or neck pain? ❑No ❑Yes. Explain _____

Any other known conditions? ❑No ❑Yes. Explain _____

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✓ Patient Name: _____

Date of Birth: _____/_____/_____

Personal Health History, continued

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

Please indicate your familial status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partnered

How many children do you have? ❑ None ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 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 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? _____

Are you sexually active? ❑ No ❑ Yes. Have you ever been diagnosed win 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 life.*

Poor **0** **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. How many times do you wake up? _____

Night sweats? ❑ No ❑ Yes.

Restless leg at night? ❑ No ❑ Yes.

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✓ Headache. *Please circle where you rate your current quality of life.*

No Pain **0** **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 aggrivates the headache? _____

What makes it better? _____

Quality of Headache? ❑ Dull ❑ Fast ❑ Throbbing

Review of Systems & 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 ❑ Pale skin ❑ Neck Pain ❑ Shortness of breath

❑ Light-Headedness ❑ Swelling in your left arm ❑ Blackouts ❑ Left arm pain

❑ Jaw pain ❑ Excessive sweating without exertion

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

❑ Nausea ❑ Difficulty with Swallowing ❑ Vomiting ❑ Dizziness or vertigo

❑ Abnormal sweating ❑ Difficulty with speaking ❑ Double vision ❑ Numbness

❑ feeling unsteady ❑ Blurred vision ❑ Balance problems ❑ Headache

✓ 5. Have you noticed any of the following?

❑ Recent fever ❑ Change in appetite ❑ Memory issues ❑ Unexplained weight loss

❑ Drowsiness ❑ Brain Fog ❑ Confusion ❑ Sensitivity Light

❑ Pressure in head ❑ Sensitivity to Sound ❑ Recent fatigue ❑ Unexplained weight gain

❑ More Emotional

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✓ Patient Name: _____

Date of Birth: _____/_____/_____

Personal Health History, continued

✓ Please mark below any of the conditions that apply to you, past or present. ❑ Past Condition ❑ Present Condition

Osteoporosis	❑	❑	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 spinal curvature	❑	❑	Sleep apnea	❑	❑	Feelings of urgency to urinate	❑	❑
Osteoarthritis or DJD	❑	❑	Cataracts	❑	❑	Leg pain with walking	❑	❑
Rheumatoid arthritis	❑	❑	Arrhythmia	❑	❑	Blood clots/phlebitis	❑	❑
Other arthritis	❑	❑	Heart murmur	❑	❑	Frequent colds or flus	❑	❑
Gout	❑	❑	Atherosclerosis/arteriosclerosis	❑	❑	Alcoholism	❑	❑
Mental or emotional disorder	❑	❑	Wheezing	❑	❑	Cancer	❑	❑
Learning disability	❑	❑	Asthma	❑	❑	Feelings of suicide	❑	❑
Glaucoma	❑	❑	Gastric ulcers	❑	❑	Infrequent urination	❑	❑
Heart palpitations (heart racing)	❑	❑	Celiac Disease (Sprue)	❑	❑	Blood in urine	❑	❑
Swelling in legs or feet	❑	❑	Irritable bowel 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	❑	❑			
Experience passing out	❑	❑	Depression	❑	❑			
Skipped heart beats	❑	❑	Prostate problems	❑	❑			
Congenital heart disease	❑	❑	Erectile dysfunction	❑	❑			
Shortness of breath with activity	❑	❑	Discharge from urethra	❑	❑			
Short of breath at rest	❑	❑	Bleeding disorder	❑	❑			
Polyps	❑	❑	Anemia	❑	❑			
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 disease	❑	❑			

Females only:

Is there any possibility that you are currently pregnant? ❑ No ❑ Yes

What was the date of your last menstrual period?

Date _____/_____/_____

Bagnell BRAIN CENTER™

Patient Name: _____

Date of Birth: _____/_____/_____

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

You may describe any other concerns or questions in this space:

_____

_____

_____

_____

_____

_____

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 Bagnell Brain Center. Any disclosure is outlined in our privacy policies.

_____ _____

Patient's (or guardian's) signature Date

_____ _____

Signature of translator or person assisting you (if any) Date

_____

Printed name

Doctor's Notes.

_____

_____

_____

_____

_____

_____ Doctor's initials: _____