NeuroGrow
BRAIN FITNESS CENTER
'BOOST YOUR BRAIN'

Patient History Questionnaire

Name: _____ **Age:** _____

Reason for Visit:

☐ Memory Loss ☐ Vertigo/Dizziness ☐ Brain Performance
☐ ADHD ☐ Concussion ☐ Other: _____

Medical problems:

1. Diabetes ☐ Yes ☐ No
2. Hypertension ☐ Yes ☐ No
3. Heart disease/attack ☐ Yes ☐ No
4. Stroke ☐ Yes ☐ No
5. Arthritis ☐ Yes ☐ No
6. Head Trauma/injuries ☐ Yes ☐ No
7. Headaches ☐ Yes ☐ No

8. Surgical issues/operations: _____
_____
_____
9. Other: _____
_____
_____
_____

Family History:

Father: Age: _____ Deceased: ☐ Yes ☐ No Health Issues: _____
Mother: Age: _____ Deceased: ☐ Yes ☐ No Health Issues: _____
Brother(s): Age: _____ Deceased: ☐ Yes ☐ No Health Issues: _____
Sister(s): Age: _____ Deceased: ☐ Yes ☐ No Health Issues: _____

Demographics:

☐ American Indian/Alaska Native ☐ Black or African American ☐ White
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Hispanic

Social History:

Tobacco: ☐ No ☐ Yes Amount: _____ ☐ Only Socially How Many Years: _____
Alcohol: ☐ No ☐ Yes Amount: _____ ☐ Only Socially How Many Years: _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Other: _____ # of children:_____

Education: ☐ High School ☐ College ☐ Postgraduate Other:_____

Exercise: ☐ Yes ☐ No How Much: _____

Hobbies: _____

Occupation: Past: _____

Present: _____

8280 Greensboro Drive, Suite 240 | McLean, VA 22102 | Phone: (703) 462-9296 | Fax: (703) 462-9269 | www.neurogrow.com

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SYMPTOMS YOU MAY HAVE EXPERIENCED IN THE PAST OR ARE EXPERIENCING CURRENTLY:

General:

☐ Weight loss ☐ Weight gain ☐ Fatigue ☐ Sleep problems
☐ Nausea ☐ Vomiting ☐ Fever/chills

Neurological:

☐ Headaches ☐ Memory loss ☐ Dizziness ☐ Vertigo (room spinning)
☐ Difficulty walking ☐ Falls ☐ Muscle pain ☐ Weakness all over
☐ Tremor ☐ Muscle spasms ☐ Sensitivity to noise ☐ Difficulty with coordination
☐ Head injury ☐ Flashing lights ☐ Sensitivity to light ☐ Pain radiating in arms & legs
☐ Back pain ☐ Neck pain ☐ Seizures
☐ Numbness and tingling in: _____

Ears/Nose/Mouth/Throat:

☐ Hearing loss ☐ Ear pain ☐ Ringing in the ears ☐ Vertigo (room spinning)
☐ Swallowing difficulty ☐ Poor vision ☐ Hoarseness or change in voice

Psychiatric:

☐ Nervousness ☐ Anxiety ☐ Panic attacks
☐ Hallucinations ☐ Depression ☐ Learning problems ☐ Difficulty with concentration
☐ Mood swings ☐ Suicidal thoughts ☐ History of drug abuse ☐ History of alcohol abuse

Cardiovascular:

☐ High blood pressure ☐ Heart murmur ☐ Heart failure ☐ Cough
☐ Shortness of breath ☐ Irregular heartbeat ☐ Syncope ☐ Angina/chest pressure
☐ Faintness/lightheadedness

Other:

☐ Ulcer disease ☐ Abdominal pain ☐ Reflux disorder ☐ Sexual dysfunction
☐ Skin problems ☐ Excessive or decreased sweating ☐ Bleeding problems
☐ Kidney problems ☐ Bladder problems

WOMEN ONLY:

☐ Number of pregnancies: _____ ☐ Miscarriages
☐ Last menstrual period: _____ ☐ Menopause
☐ Birth control pills
☐ Hormone replacement therapy

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Medications- Current: (please include over the counter, Aspirin, Aleve, Tylenol, herbs, vitamins, etc…)

	Name:	Dosage:	Times per day:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Please list your medication allergies: ☐ No Known Medication Allergies

1. _____
2. _____

Please provide detail information about your concern. Use the back of this page, if needed

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature: X_____ **Date:** _____

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