Peak Brain & Body

Name _____ Age _____ Date of Birth ____-____-_____

Social Security # _____

Address

_____

Street or PO Box Apt# City State Zip

Phone (Hm) _____ (Cell) _____ (Wk) _____

Please indicate your preferred contact number above by circling it.

Do you prefer to be contacted via email and / or phone call? (Please Circle all that apply)

E-Mail Address:_____Employer:_____

Sex: M _____ F _____ Marital Status: Single Married Widowed Div.

Spouse's Name _____ Spouse's Occupation:_____

If the patient is a minor, who are the responsible parties?

_____

How did you find out about Peak Brain and Body?

_____

Occupation, please describe what type of work you do daily (hours, night shift, stress level):

_____

Please describe what brought you into the office today (If there is a certain even please list date:

_____

_____

What activities or responsibilities are being or have been affected by the above issue?

_____

What are your top 3 goals for care?

_____

What would it mean to you if your symptoms improve?

_____

The statements made on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation. I understand some of the care provided is not FDA approved.

X_____ _____ _____

Signature (Guardians if Minor) Printed Name Date

Peak Brain & Body

Do you now or have you ever suffered from: *(Place a Y for now or X for past history)*

Dizziness ___
Frequent UTIs_____
Lazy eye ___
Headaches___
Cancer___
Brain Fog ___
Concussion ____
Tire Easily ___
Irritability___
Mood swings____
PCOS____
Concentration Challenges____
Heart palpitations or arrhythmia____
Thyroid Dysfunction____
Acne____
Speech changes____
Painful breasts or breast cancer_____
Restlessness____
Motion Sickness___
Heart disease ___
Asthma ___
Digestive Problems ___
Arthritis ___
Anxiety ___
Low Energy___
Allergies ___
Kidney stones___
Depression___
Skin Irritations_____
Adrenal dysfunction____
Memory Decline____
Reflux____
Sinus Infections ___
Light Headed ___
Diabetes ___
High Blood Pressure ___
Heart Burn ___
Sinus pain/congestion ___
Anemia ___
Poor Circulation ___
Menstrual Pain or Difficulties __
Cold/Tingling/Numbness in Hands/Feet ___
Muscle aches or arthritis_____
Frequent Colds/URIs_____
Cognitive Changes____
Balance or Coordination Decline____
Autoimmune Conditions_____
Hormone dysfunction____
Difficulty Sleeping ___
Hyperactivity____
Frequent Cravings____
Constipation ____

Have you taken multiple round of antibiotics? Yes / No
Are your symptoms worse on damp, muggy days or in moldy places? Yes / No
Do you have a feeling of being drained? Occasional or Mild / Frequent/Moderate/ Severe

Please list any other health concerns you have at this time:
_____
_____

Injury and Surgical History:
Any Accidents or Injuries (childhood, broken bones, etc.)?
_____
_____
Surgeries:_____
Any Other Medical Procedures? _____
Do you do any physical activity on a daily basis? Please Describe.
_____

Peak Brain & Body

Prescriptions and Social Habits:
List any and all Prescriptions or OTC drugs:

_____

_____

Do you smoke or chew tobacco?_____
Do you drink alcohol, how often?_____
Do you drink diet sodas or eat sugar-free foods? _____

Family History: (Please list cancers, diabetes, heart conditions, autoimmunity, genetic disorders and dementia. Also note if they are living or deceased)

Mother:_____
Father: _____
Sibling: _____

Stressful Events: Have you had any major stressful event recently or in the past that is impacting your daily life or creates increased level of symptoms?

_____

What improvements are you seeking?

___ More Energy	**___ Better Sleep**	**___ Freedom from pain**
___ Better Concentration	**___ Emotional Health**	**___ Reduce/Eliminate Medication use**
___ Improved Digestion	**___ Better Brain Health**	**___ Greater resistance to Disease**
___ Better Balance	**___ Less Headaches**	**___ Overall Health Improvement**
___ Less Allergies	**___ Weight loss**	**___ Other Not Listed**