



Dr. Jeff Brittain, D.C.
 3730 Kirby Dr. Suite 410, Houston, TX 77098
 Office 713-527-8844 Fax 877-846-6711
 Brittainhealth.com

Name: _____ Referred by: _____ Date _____

Address: _____ City _____ St _____ Zip _____

Phone: H) _____ W) _____ M) _____ Marital Status: S M D W

Email: _____ Occupation: _____ Birth date _____

Please state your primary reason for today's visit, what is your concern and what results do you want?

Family History	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List medications your take, why and when you started:

1. _____ why? _____ when? _____
2. _____ why? _____ when? _____
3. _____ why? _____ when? _____
4. _____ why? _____ when? _____
5. _____ why? _____ when? _____
6. _____ why? _____ when? _____
7. _____ why? _____ when? _____
8. _____ why? _____ when? _____

List nutritional products: minerals-vitamins-homeopathic-super foods your take, why and when you started:

1. _____ why? _____ when? _____
2. _____ why? _____ when? _____
3. _____ why? _____ when? _____
4. _____ why? _____ when? _____
5. _____ why? _____ when? _____
6. _____ why? _____ when? _____
7. _____ why? _____ when? _____
8. _____ why? _____ when? _____

Name _____ Date _____

List all your major health concerns in order of importance, and rate severity (1-mild to 10- severe)

1. _____	<input type="checkbox"/>
2. _____	<input type="checkbox"/>
3. _____	<input type="checkbox"/>
4. _____	<input type="checkbox"/>
5. _____	<input type="checkbox"/>
6. _____	<input type="checkbox"/>
7. _____	<input type="checkbox"/>
8. _____	<input type="checkbox"/>
9. _____	<input type="checkbox"/>
10. _____	<input type="checkbox"/>
11. _____	<input type="checkbox"/>
12. _____	<input type="checkbox"/>
13. _____	<input type="checkbox"/>
14. _____	<input type="checkbox"/>
15. _____	<input type="checkbox"/>
16. _____	<input type="checkbox"/>
17. _____	<input type="checkbox"/>
18. _____	<input type="checkbox"/>
19. _____	<input type="checkbox"/>
20. _____	<input type="checkbox"/>

Name _____ Date _____

What is your exercise program: type? trainer? gym? frequency? Your objective?

What are your particular diet guidelines?

What has been your experience with chiropractic doctors?

What has been your experience with medical doctors?

List physical, chemical and emotional traumas (not listed above).

Is there anything unique or unusual about your health that you think I need to know?
