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Name: _____ Referred by: _____ Date _____

Address: _____ City _____ St _____ Zip _____

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

Email: _____ Occupation: _____ Birth date _____

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 your other major health concerns in order of importance¹, and rate severity (1-mild to 10- severe)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

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?

