



**REVOLUTIONARY MD
Brain Health Program**

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888-726-4442 / phone 303-537-5639 / fax

PERSONAL INFORMATION

Name _____
Address _____
City _____ State _____ Zip _____
Email address _____

Date of birth ____/____/____
Age _____
Gender M F

Home Phone _____
Work Phone _____
Occupation _____

Cell Phone _____
Fax _____

Tell us more about your needs and desires regarding brain health
How can we help? What are you hoping to address or achieve through our Brain Health Program?

HEALTH INFORMATION

1. On a scale of 1-10, how would you rate your current health, with 1 being the worst, 10 being the best? _____

2. On a scale of 1-10, how would you rate the quality of your sleep in the past month (1=worst, 10=best)? _____

At what time do you go to bed? _____ am/pm
What time do you rise in the morning? _____ am/pm

Are you able to sleep through the night? YES NO
If not, please describe:

Are you able to fall asleep easily most nights? YES NO
If not, please describe:

Do you wake too early? YES NO
If so, please describe:

3. Have you ever injured your head or neck? YES NO
Have you ever been in an auto, motorcycle or bicycle accident? YES NO
Are you currently receiving care for this/these injuries? YES NO

Please describe (on reverse side, if you need more space), thinking back over the years of your life. Please consider home life, sports, auto accidents, slips/falls, etc.

4. Do you currently use psychoactive drugs, medications or alcohol to pick yourself up or calm yourself down?
YES NO
Have you ever used psychoactive drugs, medications or alcohol in the past to pick yourself up or calm yourself?
YES NO
Are you currently a smoker? YES NO
Do you consider your current use of tobacco, alcohol or street drugs a problem?
YES NO
If yes on any of these substances, please list here.

5. Do you feel depressed? YES NO
6. Have you suffered from depression or bipolar disease in the past? YES NO
Circle condition if yes.
7. Any history of other ADD/ADHD? YES NO
8. Any history of other psychiatric conditions such as schizophrenia? YES NO
9. Please list any chronic medical problems or brain health issues you have:
10. Please list any medication allergies you may have:
11. Please list current medications you are taking:
12. Please list any supplements you are taking:
13. Are you concerned about any hormonal imbalances that may be contributing to your condition?
YES NO
If yes, would you like to see Dr. Grover in a separate medical consultation to evaluate possible hormone imbalance? YES NO
14. Are you currently working with a psychiatrist, therapist, counselor or clergy in matters regarding your mental health? YES NO
If yes, please list name/names _____
15. Are you, or have you ever been, sensitive to lights or strobe lights, had or been diagnosed with migraines or epileptic seizures? YES NO
16. Is there anything else that you would like to add?

Parent or Guardian of Minor, please complete this section

Parent/Guardian Name _____
 Address _____ Do you live with the patient? Y N
 City _____ State ____ Zip _____ Phone _____

How did you learn about our Brain Health Program?

___ website ___ newspaper ___ friend
 ___ flyer ___ magazine ___ health care provider
 ___ other:

If you were referred to the program, whom shall we thank for the referral?

For Office Use only
 Diagnostic code(s): _____, _____, _____, _____ Date of Rx or Referral ___/___/___
 Referred by: _____
 Physician Name or Practice Name _____
 Specialty _____ State _____ Phone _____ Fax _____
 Date of visit ___/___/___ Recommendations: ___ verbal n person ___ w FU email ___ in writing ___ referral out of practice