Application for Admission
Digestive Case History

If you are reading this you have been fortunate enough to qualify for a ***consultation*** with Dr. Branham at no charge.
This however does NOT mean that your case has been accepted.
Your consultation today will determine if:
A) You are a legitimate candidate for this program and B) You are serious enough about your condition to warrant your case being accepted for treatment. In the event that Dr. Branham is UNAVAILABLE to provide care to you, your case will be referred to another clinic.

Today's Date _____

Name _____ Age _____ Birthday _____ Sex M / F

Address_____

City_____ State _____ Zip _____ SS#_____

Home Phone _____ Work Phone _____ Cell Phone_____

Best Place to Reach You (circle one) Home / Work / Cell May we leave a voice mail message for you? Yes / No

Employer _____ Occupation_____

E-mail_____ Would you like to receive e-mail updates? Yes / No

Marital Status S M W D Spouses Name _____

I (signature) _____consent to allow Dr. Branham to speak with me and perform an examination if necessary, in order to determine if I am a good candidate for care; and also to determine if he is willing to accept my case. It is also my understanding that BOTH the consultation AND examination (if necessary) are at no charge.

How Did You Hear About Dr. Branham? Referred by: _____ TV Show_____ Other_____

1. How Serious Do You Think Your Problem Is?
_____

What Is Your Main Problem(s)/Symptom(s) Prompting Your Request For A Consultation With The Doctor?
_____

Would You Consider This Problem (circle one)....
MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but definitely causing limitations)
SEVERE (Causing Significant limitations)
EXTREME (Causing near constant (>80% of the time) limitations)

1. In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and in your own opinion what do you think the real problem is?

_____
_____

2. When was the first time you remember having symptoms that could be related to a digestive problem? Describe.

_____
_____
_____
_____

3. Please list all the digestive symptoms you initially had.

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

4. Please list the digestive symptoms that persisted after the prescription medications.

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

5. Have you always thought you had a digestive problem, but never have had a confirmation via diagnosis from a doctor?

Yes or No (Please circle the appropriate response)

6. Please list all prescription medications, over the counter drugs, and supplements (vitamins) you are currently taking.

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

7. Since your digestive issues began what three things has it caused you to miss the most?

1.
2.
3.

8. Have you ever been tested for a digestive condition? (Crohns or Celiac)

Yes or No (please circle the appropriate response)

9. Have you ever been diagnosed as having a digestive condition?

Yes or No (Please circle the appropriate response)

10. Is there anything you have done on your own, outside of medical advice that improved your condition?

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11. If you cannot find a solution to your health problems what do you think will happen to you?

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12. What are you hoping the doctor tells you today?

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13. Describe what you hope or think he might be able to do for you.

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14. Describe what will be different in your life if you can finally be relieved of these problems.

List, in Order of Importance, OTHER Health Problems/Concerns NOT including Your Main Problem Above.

1._____ How Long Have You Had This?_____
2._____ How Long Have You Had This?_____
3._____ How Long Have You Had This?_____
4._____ How Long Have You Had This?_____

Due To Your Main Problem.....

Have You Lost Any Time From Work? Yes No
How Much Time and What Tasks Have Been Limited?
_____
Have You Lost Any Time From Your Chores/Tasks At Home? Yes No
How Much Time and What Tasks Have Been Limited?
_____
Have You Lost Any Time From Your Family? Yes No
How Much Time and What Tasks Have Been Limited?
_____
Have You Lost Any Time From Your Leisure Activities? (Hobbies, Travel, Sports, etc...) Yes No
How Much Time and What Tasks Have Been Limited?
_____

Please list your health goals in order of importance.

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

On a Scale of 0-10 (10 being the most motivation possible, 0 being No Motivation at all) Please rate your motivation to achieve the above health goals by circling the appropriate number below.

0 1 2 3 4 5 6 7 8 9 10

List ANY surgeries that you have had and the corresponding dates.

1._____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you had ANY of the following in the last 12 months or currently.
(Mark C for Current. X for in last 12 mos.)

GENERAL
Chills ____ Convulsions ____ Dizziness ____ Fainting ___ Fatigue ____ Fever ____ Headache ____ Loss of Sleep ____Allergy ____ (to what_____) Loss of Weight ____ Nervousness ____ Wheezing ____ Bronchitis ____
Numbness in BOTH hands AND feet ____

CARDIOVASCULAR
High Blood Pressure ____ Low Blood Pressure ____ Pain over heart ____ Poor Circulation ____ Rapid Heartbeat ___Previous Heart Problem ____ (Describe _____) Slow Heartbeat ____ Stroke ____ TIA ____Swollen Ankles ____ Varicose Veins ____ Aortic Aneurysm ____ Bruise Easily ____

DISEASES/CONDITIONS
Appendicitis ____ Anemia ____ Arthritis ____ Alcoholism ____ Abdominal Surgery ____ Bleeding Disorder ____Blood Clot(s) ____ Breathing Difficulty ____ Cancer ____ Cholesterol High ____ Colon Problems ____ Diabetes ____ Depression ____ Epilepsy ____ Eczema ____ Eating Disorder ____ Glaucoma ____ HIV + ____ Heart Disease ____Hernia ____ Headaches ____ Influenza ____ Kidney Disease ____ Liver Disease ____ Low back Pain ____Mental Illness ____ Measles ____ Mumps ____ Pleurisy ____ Pneumonia ____ Polio ____ Prostate Problems ____Hyperthyroid ____ Hypothyroid ____ Rectal Surgery ____

EARS/EYES/NOSE/THROAT
Asthma ____ Crossed Eyes ____ Double Vision ____ Blurred Vision ____ Difficulty Swallowing ____Deafness ____Hearing Loss ____ Ear Pain ____ Thyroid Problem ____ Nose Bleeds ____ Sinus Problems ____ Sore Throats ____

GASTRO-INTESTINAL
Gas ____ Colon Trouble ____ Constipation ____ Diarrhea ____ Gallbladder Trouble ____ Hemorrhoids ____Liver Trouble ____ Nausea ____ Stomach Ache ____ Poor Appetite ____ Poor Digestion ____ Vomiting ____Vomiting Blood ____ Rectal Bleeding ____ Bloating ____

GENITO-URINARY
Blood in Urine ___ Frequent Urination ___ Inability to control urine ____ Kidney Infection ____ Painful Urination ____Prostate Trouble ____ Painful Urination ____

FOR MEN ONLY
Lump in testicles ____ Penis discharge ____

FOR WOMEN ONLY
Menstrual Cramps ____ Excessive menstrual flow ____ Hot Flashes ____ Irregular Cycle ____ Painful periods ____Birth Control Pills ____ Abnormal Pap Smear ____

MUSCLE/JOINT/BONE
Backache ____ Foot Trouble ___ Pain between Shoulders ____ Painful Tailbone ____ Stiff Neck ____Spinal Curvature ____ Swollen Joints ____

NEUROLOGIC
Seizures ____ Dizziness ____ Hand Trembling ____ Weakness ____ Difficulty with speech ____ Loss of memory ____Loss of coordination ____

RESPIRATORY
Chest Pain ____ Chronic Cough ____ Difficulty Breathing ____ Coughing/Spitting Blood ___