**Application For Admission**

***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 your condition, please describe?

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Please list all the symptoms you currently have.

 1. 6.

 2. 7.

 3. 8.

 4. 9.

 5. 10.

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

 1.

 2.

 3.

9. Have you ever been tested for an auto-immune thyroid condition? (Hashimoto’s Thyroiditis)

 Yes or No (please circle the appropriate response)

10. Have you ever been diagnosed as having an auto-immune thyroid?

 Yes or No (Please circle the appropriate response)

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

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

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

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

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

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**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 \_\_\_

If an appointment needs to be cancelled, we need a 24 hour notice to reschedule it.

**Notice: If you do not show for a scheduled appointment without cancelling, you will be charged $25 for that session.**