

PREMIER HEALTH CARE

Dr Sean Branham D.C.

8970 Watson Rd.
St. Louis, MO 63119
(314) 647-1384 Phone
(314) 270-8113 Fax

Dear Friend,

You should know that your visit in our practice today is not a sales presentation, there is nothing to buy and you cannot become a patient in our practice today.

Our process for admitting patients is typically a two day process, both of which are complimentary. Your first visit may be in a group setting; we will be giving you valuable health information regarding your specific condition. The second visit is always one on one with a doctor and geared mostly around understanding your individual needs and whether or not you can be admitted as a patient under our care.

Before you see a doctor you will be allowed to view video patient testimonials with the intent of showing what may be possible with your own health should you be a good fit for our practice.

Our practice, due to many factors, mainly our clinical success, has grown to levels where we cannot possibly see every potential patient one on one for both visits. If you are uncomfortable with this process then simply make our front desk aware and we will attempt to accommodate your needs at another time.

Warmly,

Dr. Sean Branham, D.C.

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?

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

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

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

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 ___