

PREMIER HEALTH CARE

Dr Sean Branham D.C.

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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.

Complimentary Consultation Terms

1. I understand that today's consultation is complimentary and is used to determine whether or not I am a candidate for care.
2. I understand that the consultation process does not establish me as a patient under Dr. Branham's care and there is no doctor-patient relationship or obligation.
3. I am aware that after the consultation, I may not be accepted as a patient.
4. I understand that Dr. Branham is not able to and does not accept every case. Dr. Branham's schedule is extremely busy and he strictly limits the number of new patients he accepts so as to ensure a high quality of care.
5. Please fill out all paperwork completely to the best of your knowledge. Do not leave anything blank. If paperwork is not filled out completely Dr. Branham may refuse to do the consultation.
6. I understand that the information given to me is proprietary and agree not to disclose any terms of this information under penalty of law.
7. It is imperative that you are under the care of a medical doctor or a doctor licensed to prescribe medication. Please list below the name and contact information of that physician.

Name of Physician

Phone number

I have read, understand and accept the terms of the complimentary consultation.

Name (please print)

Signature

Date

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

EAR/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