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.

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
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 low thyroid condition, please describe?

_____

_____

_____

_____

_____

_____

3. Please list all the symptoms of low thyroid you initially had.

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

4. Are you currently taking thyroid hormones or have you taken thyroid hormones in the past?

Yes or No (Please circle the appropriate answer)

5. Please list the symptoms of low thyroid that persisted after the prescription of thyroid hormones.

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

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

Yes or No (Please circle the appropriate response)

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

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

7. Since your thyroid 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.

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 ____