BROUSE
Chiropractic & Nutrition

PATIENT APPLICATION FORM

WELCOME TO OUR OFFICE!

We are here to help you achieve a superior level of health for you and your family!

Our approach is very unique and advanced which allows our patients to achieve far superior results compared to most other systems.

We have **UNIQUE QUESTIONS** in this application that will allow us to **Discover Health Dangers & Analyze Disease Causation**.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. If you come across something that doesn't apply, **please write N/A**, instead of leaving it blank. Please feel free to ask any questions if you need assistance. We look forward to serving you!

Patient Signature:____

Today's Date:_______________________________________

How were you referred to this office?:_______________________________

Health Assessment Questionnaire

Date:_______________

(If there is something that does not apply to you, please put N/A)

Name: ____(Age) ______ Gender: M F

Home Address:____ **Circle** Best # to reach you: Home Cell Work

City, State, Zip:____ Home Phone: ( )_____________________________

Email Address: ____ Cell Phone: ( )_____________________________

Birth Date:_____/______/______ Social Security #: _______-_______-_______ Work Phone: ( )_____________________________

Names and Ages of Children:______________________________________ Marital Status: S M D W

Occupation: ____Employer Name:____

Spouse's/Significant Other's Name:________________________ Cell Phone: ( )____

Spouse/Sig. Other Employer:____________________________ Occupation:____

Emergency Contact:____________________________________Phone Number:____

Your Primary Concern Today

What is the primary reason for visiting our office today? (Please check only one)

_____ Spinal Reconstructive Care - To find out if I qualify for Relieving, Stabilizing and Correcting spinal damage

_____ Relief Care - To relieve my symptoms of pain or discomfort

_____ Prevention - To maximizing my body's function for the highest degree of health

_____ I want the doctor to inform me of the type of care that is best for me

Please check one of the following if you are interested in a weight loss and /or nutrition evaluation

_____ I am here for weight loss and/or nutrition only

_____ I am interested in both a nervous system evaluation(chiropractic) & weight loss/nutrition evaluation

What, if any, is your main area of complaint today?____

Is this condition related to an **auto/ work injury**? **Yes** **No** If so, when?____________________________

How long have you been aware of this? ________ Days _________ Weeks ___________ Months __________Years

What caused it? ____

What makes it worse?____

Is there anything that makes it better? Yes No Describe:____

Type of Pain: ☐ Sharp/Stabbing ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Spasm ☐ Numb ☐ Tingling

Does the Pain Travel anywhere in your body? Yes No If yes, where?____

How often do you experience this? ____ Daily ____ Weekly _____ Monthly _____ Comes and Goes _____ Constantly

On a scale of 1 to 10, How does it feel when it is at it's worst? (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Have you recently had any tests done to help diagnose this condition? ____ Yes ____ No

Do you have any other concerns you would like us to discuss with you today?____

____

Please list any vitamins or supplements you are taking. ____

____

Please list all medications, prescriptions, and over the counter drugs (or provide a list to copy if over 8 drugs.)

1.______________________Reason__________________5.______________________Reason____________________

2.______________________Reason__________________6.______________________Reason____________________

3.______________________Reason__________________7.______________________Reason____________________

4.______________________Reason__________________8.______________________Reason____________________

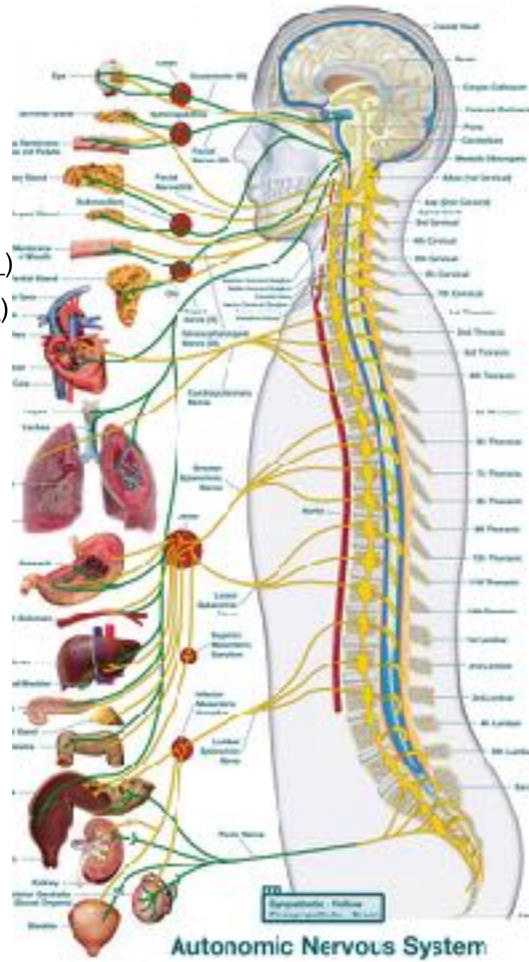
Have you ever been to a Chiropractor before? Yes No Circle your past experience? (Bad) 0 1 2 3 4 5 6 7 8 9 10 (Great)

Why are you thinking of changing chiropractors?____

PLEASE CHECK ANY OF THE FOLLOWING SIGNS OF ORGAN

MALFUNCTION OR DIS-EASE YOU HAVE EXPERIENCED

- Visual/ Hearing Disturbances
- Ear infections/ Ringing in Ears
- Sore throat/tonsilitis
- Thyroid problems
- Allergies/ Sinus Problems
- Dizziness/Fainting
- Low Energy/ Fatigue
- Headaches (How often__________)
- Migraines (How often___________)
- Frequent Colds/Flu
- Fever/Chills/Sweats
- Seizures/Convulsions
- Poor Memory/Concentration



Respiratory System

- Recurring Bronchitis/Pneumonia
- Chronic cough
- Spitting up phlegm/blood
- Difficulty breathing
- Asthma/Wheezing

Musculoskeletal System

- Poor Posture
- Neck Pain/Stiffness
- Pain into shoulders/arms/hands
- Numbness/Tingling: arms/hands/fingers
- Tension across shoulders, L R
- Mid-back pain/ stiffness
- Pain on inspiration/exhalation
- Pain into your ribs/chest
- Low back pain/stiffness
- ? Pain into hips/legs/feet L R
- Numbness/tingling: Legs/Feet
- Hip Pain L R
- Scoliosis/ Spinal Curvature
- Disc Degeneration/Bulge/Herniation
- Foot trouble, L R
- Painful Muscles
- Tendonitis ____________________
- Bursitis ______________________
- Arthritis ______________________

Cardiovascular System

- Chest pain
- Shortness of Breath
- Heart Medication
- Heart Palpitations
- Heart Murmurs
- Tachycardia (Rapid Heartbeat)
- Heart Attacks/Angina
- High Blood Pressure
- High Cholesterol
- Swelling of Legs
- Coldness in hands or feet
- Worried about Heart Disease

Date:______________

General Symptoms

- Skin problems __________________
- Tremors
- Loss of balance
- Unexplained weight loss/gain
- Anemia
- HIV/AIDS
- Loss of sleep
- Anxiety/Depression
- Difficulty Sleeping
- Autoimmune Disease
- Cancer:_______________________
- Recurring bladder Infections
- Frequent/Difficulty Urinating
- Prostate Problems________________
- Sexual Dysfunction/Impotence
- Infertility
- Immune Problems

Digestive System

- Heartburn/Indigestion
- Stomach Cramps
- Constipation
- Diarrhea
- Irritable Bowel Syndrom (IBS)
- Crohn's Disease/Colitis
- Ulcers/Gastritis
- Belching/Gas
- Nausea/ Vomiting
- Gall Bladder trouble_____________
- Liver trouble __________________
- Kidney trouble_________________
- Colon trouble _________________
- Black/ bloody stool
- Celiac's

WOMEN ONLY

- Currently Pregnant
- Excessive/Irregular flow
- Excessive Cramping/Pain
- Hot Flashes
- Passed Menopause
- Hysterectomy

Please list any health conditions not mentioned:__________________________

PREVIOUS TRAUMAS

Date:_______________

Please indicate year(s) of any Accidents and injuries: **Vehicle accidents:**______________________________

Sports Injuries:_________________________________ **Falls:**____

Work Injuries:__________________________________

What surgeries or hospitalizations have you had?____

Have you ever had a **stroke** or any **cardiac event**?____

What **broken bones** have you had?____

EMOTIONAL STRESS

Are you currently experiencing, or have you experienced significant stress in the following areas?

- Marriage __________________________________
- Kids _____________________________________
- Finances __________________________________
- Work _____________________________________
- School ____________________________________
- Elderly Parents- Caregiver ___________________
- Recent Major Life Events (births, deaths, Sickness) ____________________________________

CHEMICAL STRESSES:

Do you and how much much?

- Smoke? How much?__________________
- Chew? How much?____________________
- Alcohol? How much?__________________
- Take Recreational Drugs? How much? ______________
- Coffee or Soda? How much?______________________
- Fast Food? How often?___________________________

EXERCISE

Do you exercise? Yes No

If Yes, How often?________________ days a week

**FOR CHILDREN UNDER 18 YEARS OF AGE

<u>Consent to evaluate and treat a minor child:</u>

I, _________________________, being the parent or legal guardian of __________________________ fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**Signature________________________ **Date:_____________________

FOR WOMEN ONLY

<u>Pregnancy Release:</u>

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can harm a fetus (unborn child) in the early stages.

Date of last menstrual period___________________

Signature____ Date______________________

INSURANCE/HIPAA INFORMATION

DO YOU HAVE INSURANCE? □ YES □ NO
*PLEASE PRESENT INSURANCE CARDS FOR VERIFICATION
(If Under Spouse, please give us Spouse's Full Name:____________________________ Spouse's DOB________________)

Assignment and Release
I certify that I, and/or my dependent(s), have insurance coverage with insurances that I presented to Wellness 1st, P.C., DBA (Brouse Family Chiropractic) and assign directly to Wellness 1st, P.C., Brouse Family Chiropractic and Dr. John Brouse all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the treatment plan is completed or one year from date signed below.

Notice of Privacy Practices
I have received a copy of the HIPAA Privacy Regulations and understand that my private healthcare information is protected.

Informed Consent
I have received a copy of the informed consent to have chiropractic treatment administered and give Dr. John Brouse consent to treat utilizing chiropractic care.

I have read over and understand the additional terms of acceptance and Insurance/HIPAA information.

Signature of patient/parent____

Date:______________________ Relationship to patient_______________________

Terms of Acceptance and Consent to Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.
Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity

Vertebral Subluxation: A misalignment of one or more of the 26 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessoning of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.
I,__________________, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to complete satisfaction.

I, therefore, accept chiropractic care on this basis. Sign_______________________ Date__________________

Nutrition Questionnaire

If you are interested in a nutritional evaluation, please fill out the following pages

What is the main thing you would like help with?____

Any other health concerns? ____

Social History

Do you live on a farm? ____ Yes ____ No If yes, do you have animals? ____ Yes ____ No

Do you grow produce on your farm? ___ Yes ___ No If yes, do you spray with pesticides? ____ Yes ____ No

Do you live near a farm? ___ Yes ___ No If yes, do they spray with pesticides? ___ Yes ___ No ___ Unsure

Have you experienced any major losses in your life? ___ Yes ____ No If yes, please explain ______________________

____

Please list all of the jobs you have had including your current occupation____

____

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or abuse is now an issue in your life, it is very important that you feel safe in telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

Did you feel safe growing up? ____ Yes ____ No

Have you been involved in abusive relationships in your life? ____ Yes ____ No

Was alcoholism or substance abuse present in your childhood home? ____ Yes ____ No

Is alcoholism or substance abuse present now in your relationships? ____ Yes ____ No

Do you currently feel safe in your home? ____ Yes ____ No

How many times have you taken antibiotics in your life? ___ Never ___Less than 5 times ___ Over 10 times ___ I've lost count

Diet Assessment

How often do you chose organic fruits and vegetables? ___ Never ____ Occasionally ____ All the time

Do you have any symptoms **immediately** after eating such as gas or bloating, etc? _____ Yes _____ No If yes, What?______

____

Do you have any **delayed** symptoms after eating such as fatigue or muscle aches, etc? ____ Yes ____ No If yes, What?

____

Do you have trouble eating because of dentures or loose teeth? ____ Yes ___ No

Do you prepare the meals at home? ____ Yes ____ No If No, who does? ________________________________

How important is religion or spirituality for you and your family?

______ Not important ____ somewhat important _____ extremely important _____ I prefer not to answer

What food allergies do you have?____

Did you ever have mononucleosis? ___ Yes ____ No ___ Not sure **Have you lived or traveled outside US?** ___ Yes ___ No

Check All That Describe Your Eating Habits

____ I eat out at restaurants ___ times a week
____ I am a stress eater
____ Chocolate is my weakness
____ I tend to snack all day
____ Work is my downfall
____ I am always hungry
____ Parties and social events are my downfall
____ I have terrible cravings
____ Food loves me and I love it
____ I hate to cook
____ Eating healthy is too expensive
____ Traditions and my culture are my challenge
____ Medical reasons effect my habits
____ I have low self esteem
____ Salty foods are my weakness
____ I am an emotional eater
____ I don't know what to eat
____ I tend to snack at night
____ I hate to exercise
____ I am easily influenced by peers
____ I struggle with meal planning
____ I'm a picky eater
____ Too busy
____ No energy to cook
____ I don't know what to cook
____ Home is my downfall
____ I lack focus
____ I lack motivation
____ I'm a negative person
____ No energy around 3 PM

Bowel Movements

Frequency

____ More than 3x a day ____ 1-3x a day ____ 4-6x a week ____ 2-3 x a week ____ 1 or less x a week

Consistency

____ soft and formed ____ difficult to pass ____ diarrhea ____ small and hard ____ loose and watery

Toxin Exposure

Do you have mercury amalgam fillings? ____ Yes ____ No
Do you have any artificial joints? ____ Yes ____ No
Have you to your knowledge been exposed to toxic metals in your home or workplace? ____ Yes ____ No ____ Unsure
Do you have a swimming pool? ____ Yes ____ No Do you have a hot tub? ____ Yes ____ No

For Women Only

Have you ever had a miscarriage? ____ Yes ____ No If yes, how many? ____
Have you ever had an abortion? ____ Yes ____ No If yes, how many? ____
Did you have any problems during your pregnancies? ____ Yes ____ No If yes, what ________________________________

Age at first period_______ Date of last pap smear _________ Were the results ____ Normal? ____ Abnormal? ____
Have you ever had an abnormal pap smear? ___ Yes ____ No

Date of last mammogram________ Were the results ____ Normal ____ Abnormal?____
Have you ever had an abnormal mammogram? ____ Yes ____ No

Have you ever used birth control pills? ___ Yes ____ No Did they agree with you? ____ Yes ____ No
Have you ever used any other type of contraceptive? ____ Yes ____ No If yes, what kind? ____________________________

If you have been through menopause, are you currently taking hormone replacement therapy? ____ Yes ____ No

Did you drink a lot of milk growing up? ____ Yes ____ No Do you drink a lot of milk now? ____ Yes ____ No

What brand of make-up do you wear? ______________________ What type of deodorant? _____________________
If you are still have menstrual cycles, what brand of products do you use? ______________________________________

What brand and types of hair products do you use like shampoo, hairspray, etc. ___________________________________

____

Food Recall Sheet

Please list the foods you ate within the last two days.

Day 1
Breakfast____

____

Lunch ____

____

Dinner ____

____

Snacks ____

What did you drink? _________________________________

Day 2
Breakfast ____

____

Lunch ____

____

Dinner ____

____

Snacks ____

What did you drink? _________________________________