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) ___________ Birth Date:________/________/________

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

City, State, Zip:____Home Phone: ( )______________________

Email Address: ____ Cell Phone: ( )____________________

Names and Ages of Children AT HOME:____ Marital Status: S M D W

Occupation: _____________________________________Employer Name:____

Spouse's/Significant Other's Name:_________________________ Occupation:____

Emergency Contact:____________________________________Phone Number: ( )_______________________________

Your Primary Concern Today

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

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

_____ Relief and Corrective Care- To relieve my symptoms as fast as possible and actually FIX the PROBLEM.

_____ Prevention/Wellness Care- Maintenance given after relief and corrective care for optimal health and healing

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

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

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)

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_____________________

What **surgeries** or **hospitalizations** have you had**?**____

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

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

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?____

Date:_______________

PLEASE CHECK ANY OF THE FOLLOWING SIGNS OF ORGAN MALFUNCTION OR DIS-EASE YOU HAVE EXPERIENCED

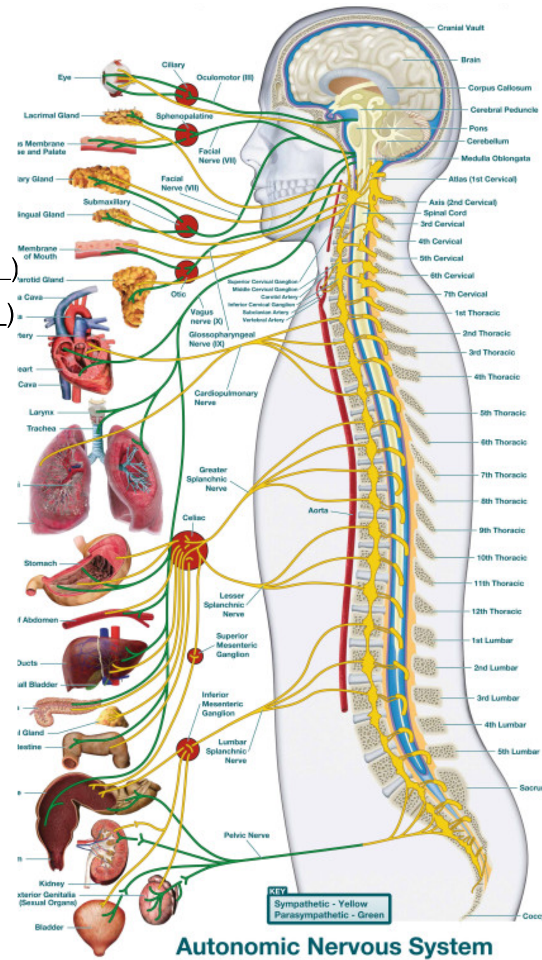
- ○ Ear infections/ Ringing in Ears
- ○ Thyroid problems
- ○ Allergies/ Sinus Problems
- ○ Dizziness
- ○ Low Energy/ Fatigue
- ○ Headaches (How often___________)
- ○ Migraines (How often___________)
- ○ Frequent Colds/Flu
- ○ Fever/Chills/Sweats
- ○ Seizures/Convulsions
- ○ Poor Memory/Concentration

Respiratory System

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

Musculoskeletal System

- ○ 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
- ○ Disc Degeneration/Bulge/Herniation
- ○ Foot trouble, L R
- ○ Arthritis ______________________



Autonomic Nervous System

Cardiovascular System

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

General Symptoms

- ○ Skin problems ______________________
- ○ Tremors
- ○ Loss of balance
- ○ HIV/AIDS
- ○ Anxiety/Depression
- ○ Difficulty Sleeping
- ○ Cancer:_________________________
- ○ Recurring bladder Infections
- ○ Frequent/Difficulty Urinating
- ○ Prostate Problems_________________
- ○ Sexual Dysfunction/Impotence
- ○ Infertility
- ○ MS
- ○ Chronic Fatigue
- ○ Fibromyalgia
- ○ Diabetes
- ○ Lupus
- ○ Grave's
- ○ Restless Leg Syndrome

Digestive System

- ○ Heartburn/Indigestion
- ○ Constipation
- ○ Diarrhea
- ○ Irritable Bowel Syndrom (IBS)
- ○ Crohn's Disease/Colitis
- ○ Nausea/ Vomiting
- ○ Gall Bladder trouble______________
- ○ Liver trouble ____________________
- ○ Kidney trouble___________________
- ○ Colon trouble ___________________
- ○ 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 & IMPACTS

Date:_______________

1) How many **total accidents** have you had? **AUTO**_________ **ATV**___________ **Motorcycle**__________

2) How many concussions have you had? __________________

3) Have you ever . . . (please circle) fallen down stairs slipped on ice or snow had a sports injury

4) Do you . . .(please circle) sit more than four hours a day drive more than two hours a day stand long periods of time

STRESS

1) Level of stress 1-10 (10 = highest) Work: _________ **Home:** _________

2) **CHEMICAL STRESSES: Do you and how much?**

Smoke? How much?____________ Chew? How much?___________ Alcohol? How much?___________

Coffee or Soda? How much?______________________ Fast Food? How often?__________________________

EXERCISE Do you exercise? Yes No If Yes, How often?________________ days a week

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What **activities** would you like to do that your health is **impairing** or **stopping** you from doing?________________________

____

How is your condition **affecting your family or loved ones**?____

____

What will happen if you **continue down the path you are on now**?____

Are you ready to get this **FIXED?** (No) 0 1 2 3 4 5 6 7 8 9 10 (Absolutely Yes)

**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. <u>We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation</u>. 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___________________