BROUSE
Chiropractic & Nutrition

CLIENT APPLICATION

WELCOME TO OUR OFFICE!

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

Our approach is very unique and advanced which allows our clients to achieve far superior results.

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 nutritionist 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!

Client 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:_____/_____/_____ Marital Status: S M D W

Occupation: _____Employer Name:_____

Emergency Contact:_____Phone Number:_____

Your Primary Concern Today

What would you like help with today?_____

_____

How long have you been aware of this? _____ Days _____ Weeks _____ Months _____Years

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

If yes, what tests?_____

_____

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_____

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

Have you ever been diagnosed with any health condition(s)? _____

_____

PREVIOUS TRAUMAS

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**?_____

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

Have you ever been diagnosed with HPV? __Yes ___ No **Scarlet Fever** ___ Yes ____ No

Have you ever tested positive for Lyme disease? __Yes ___No

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 important is religion or spirituality for you and your family?
_____ Not important ____ somewhat important _____ extremely important _____ I prefer not to answer

Toxin Exposure
Do you have mercury amalgam fillings? ____ 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. _____

Date:_____

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? _____

What food allergies do you have?_____

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

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

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

Food Recall Sheet

Please list the foods you ate within the last two days. Try to be as specific as you can.

Day 1
Breakfast_____

_____

Lunch _____

_____

Dinner _____

_____

Snacks _____

What did you drink? _____

Day 2
Breakfast _____

_____

Lunch _____

_____

Dinner _____

_____

Snacks _____

What did you drink? _____

What foods/drinks are you not willing to give up that you know are not good for you? Be Honest!

_____

_____

**FOR CHILDREN UNDER 18 YEARS OF AGE

Consent to evaluate and treat a minor child:

I, _____, being the parent or legal guardian of _____
fully understand the above terms of acceptance and hereby grant permission for my child to receive a nutritional evaluation.

**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. If just seeking nutrition counseling I understand that I am financially responsible for all charges because these services are not covered by insurance. I authorize the use of my signature on all insurance submission, if I eventually decide to become a patient of Dr. John Brouse. 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 and nutrition counseling by Casey Brouse MSACN.

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

Signature of patient/parent_____

Date:_____ Relationship to patient_____