

Your appointment date: \_\_\_\_\_ Time: \_\_\_\_\_  
Referred By: \_\_\_\_\_ Event: \_\_\_\_\_

# BROUSE FAMILY CHIROPRACTIC WELCOMES YOU ☺

Application for Care - Please Print Clearly

General Information- All your information will remain confidential and is subject to HIPAA privacy laws

Patient's Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Patient's Address \_\_\_\_\_  
Street City, State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Email Address \_\_\_\_\_ (if you have one, please make sure we have this, thanks ☺)

Would you like to receive a FREE Monthly Newsletter on the latest in Health?  Yes  No

Patient's Employer \_\_\_\_\_  Full Time  Part Time  Retired  Student

Occupation \_\_\_\_\_  M  S  D  W Spouse's Name \_\_\_\_\_ # of Children \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

\*\*\*\*\* REFERRED BY: \_\_\_\_\_ (VERY IMPORTANT)\*\*\*\*\*

Major Complaint or Reason for visit: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Date of Onset? \_\_\_\_\_

Have you lost workdays?  YES  NO If YES, how many? \_\_\_\_\_

Have you had a similar condition before?  YES  NO If YES, when? \_\_\_\_\_

\*\*\*Is this condition accident related?  AUTO  WORK If YES, when \_\_\_\_\_

When was your last auto accident? \_\_\_\_\_

When were the ones before that? \_\_\_\_\_

\*\*\*\*\*

Previous Chiropractic Care?  YES  NO Chiropractor's name? \_\_\_\_\_

What was the **reason** for your initial visit? \_\_\_\_\_

What 'spinal maintenance programs' were you given to maximize the future stability of your spine? \_\_\_\_\_

Did you follow it?  YES  NO if not, why? \_\_\_\_\_

Why are you changing chiropractors? \_\_\_\_\_

What surgeries have you had? \_\_\_\_\_

What head injuries have you had? \_\_\_\_\_

What broken bones have you had? \_\_\_\_\_

What falls or dislocations have you had? \_\_\_\_\_

**PLEASE, List any and all drug and medications you now take (prescription and over-the-counter) Also, if you are able, please list what the drug is for.**

\_\_\_\_\_  
\_\_\_\_\_

Name other doctors you have seen for this condition \_\_\_\_\_

\*\*What are your health goals? \_\_\_\_\_

\_\_\_\_\_

How do you expect to achieve them? \_\_\_\_\_

\_\_\_\_\_

A **Subluxation** is when one or more of the bones of the spine becomes misaligned causing direct pressure on the brain stem, spinal cord or spinal nerves. Untreated subluxations cause weakened or distorted postures. Subluxations and postural distortions have been linked to the following health conditions.

**Please check any health conditions that you are experiencing or have experienced in the past.**

**CERVICAL SPINE (NECK):**

The following health conditions are related to the cervical spine and nervous system. Check all that apply now or in the past.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Neck Pain                               | <input type="checkbox"/> Headaches (How often _____) | <input type="checkbox"/> Sinus Problems      |
| <input type="checkbox"/> Pain into your shoulders/arms/hands     | <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Allergies/Hay fever |
| <input type="checkbox"/> Numbness/Tingling in arms/hands, finger | <input type="checkbox"/> Visual/Hearing Disturbances | <input type="checkbox"/> Recurring colds/Flu |
| <input type="checkbox"/> Coldness in hands or feet               | <input type="checkbox"/> Weakness in grip            | <input type="checkbox"/> Thyroid conditions  |
| <input type="checkbox"/> Ear Infections/Ringing in Ears          | <input type="checkbox"/> Carpal Tunnel               | <input type="checkbox"/> Shoulder Pain R/L   |

**THORACIC SPINE (UPPER BACK):**

The following health conditions are related to the upper thoracic spine and nervous system. Check all that apply now or in the past.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart Palpitations             | <input type="checkbox"/> Recurring lung infections/bronchitis | <input type="checkbox"/> Chest pain      |
| <input type="checkbox"/> Heart murmurs                  | <input type="checkbox"/> Asthma/wheezing                      | <input type="checkbox"/> Upper back pain |
| <input type="checkbox"/> Tachycardia (rapid heart beat) | <input type="checkbox"/> Shortness of breath                  |  |
| <input type="checkbox"/> Heart attacks/angina           | <input type="checkbox"/> Pain on deep inspiration/expiration  |  |

**THORACIC SPINE (MID-BACK):**

The following health conditions are related to the mid-thoracic spine and nervous system. Check all that apply now or in the past.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Mid back pain             | <input type="checkbox"/> Nausea           | <input type="checkbox"/> Tired/irritable after eating or when you haven't eaten |
| <input type="checkbox"/> Pain into your ribs/chest | <input type="checkbox"/> Ulcers/Gastritis | for awhile  |
| <input type="checkbox"/> Indigestion               | <input type="checkbox"/> Hypoglycemia     | <input type="checkbox"/> Heartburn  |

**LUMBAR SPINE (LOW BACK):**

The following health conditions are related to the lumbar spine and nervous system. Check all that apply now or in the past.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Pain into your hips/legs/feet         | <input type="checkbox"/> Recurring bladder infections                | <input type="checkbox"/> Numbness/tingling in your legs/feet |
| <input type="checkbox"/> Frequent/difficulty urinating         | <input type="checkbox"/> Coldness in your legs/feet                  | <input type="checkbox"/> Constipation/Diarrhea               |
| <input type="checkbox"/> Menstrual irregularities/cramping/PMS | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles |  |
| <input type="checkbox"/> Prostate Problems                     | <input type="checkbox"/> Impotence                                   | <input type="checkbox"/> Low back Pain                       |

**HABITS:**

Smoking Packs/Day \_\_\_\_\_ Alcohol Drinks/week \_\_\_\_\_

Coffee/Caffeine Cups/Day \_\_\_\_\_ High Stress Level Reason \_\_\_\_\_

**Brouse Family Chiropractic**

**Dr. John D. Brouse**

1104 W. High St., Unit 4A, Ebensburg, PA 15931

**(814) 472-9355**

Our office goals for you, Straight Chiropractic  
&  
Terms of Acceptance here

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both 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 lessening 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 findings, 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.  
(please, print your name)

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. \*\* \_\_\_\_\_  
Signature Date

**\*\*\*\*\*FOR WOMEN ONLY\*\*\*\*\***

**Pregnancy Release:**

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** \_\_\_\_\_

**Consent to evaluate and treat a minor child:**

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_  
have fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. **\*\*Signature** \_\_\_\_\_ **\*\*Date:** \_\_\_\_\_

## **Additional Terms of Acceptance**

We are committed to **you**, and helping you and your family to understand your health condition.

In order to achieve this, the following is our policy regarding going over your x-ray results:

Should the Doctor determine that you have subluxation, nerve damage or dysfunction, or degeneration (or any other serious conditions on your x-rays),

**YOUR SPOUSE will be required** to attend the immediately scheduled doctor's report of your exam/xray findings.

This is for your own safety and benefit.

This is also because:

1. The vital nature of the information being given to you at this report.
2. If we are able to accept you for care, and should you decide to have us help you, we will need to discuss and make insurance or other financial arrangements with you at that time.  
(Money Talk)
3. To help with any treatment choices and options.
4. Your spouse will need to help with supportive home care.

**In order for us to accept you as a patient,**  
**THIS IS A REQUIREMENT with NO EXCEPTIONS:**

This will also prevent having to go over an x-ray/exam finding more than one time per patient (prevent unnecessary work) and minimize charges and costs to you.

(Due to our large treating patient volume, and the large time requirement for explanations of x-rays, we can only go over x-rays as our current schedule allows)

Currently, we go over x-rays on **Wednesday evening at 6:30 pm.**

The Doctor is willing to contact any employers for excused absence needs.

Your cooperation is appreciated.

I have read, understand, and agree to the above additional terms of acceptance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*\*\* Vertebral Subluxations can cause your pain \*\*\*\***

**# 1 Major Complaint:** \_\_\_\_\_

*How long* has it bothered you? \_\_\_\_\_

What caused it? \_\_\_\_\_

**Vertebral Subluxations can cause irritation to different fibers within nerves.**

Is your pain *sharp* or *dull*? \_\_\_\_\_

**Subluxations can put pressure on the spinal cord which can be constant or come and go.**

Which do you feel? \_\_\_\_\_

Does this **radiate** into an extremity or stay in one area? \_\_\_\_\_

**Irritation to nerve roots can lead to discomfort,**

Circle your level of discomfort (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

\*\*\*\*\*

**# 2 Major Complaint:** \_\_\_\_\_

How long has it bothered you? \_\_\_\_\_

What caused it? \_\_\_\_\_

Is it sharp or dull? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does this radiate into an extremity or stay in one area? \_\_\_\_\_

Circle your level of discomfort (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

\*\*\*\*\*

**Any Additional Complaints:** \_\_\_\_\_

\_\_\_\_\_

\*\*\*\*\*

Is there anything that make any of the conditions above Better? \_\_\_\_\_

Is there anything that make any of the conditions above Worse? \_\_\_\_\_

\*\*\*\*\*

**Check Activities or movements that are painful to perform:**

- Sitting
- Standing
- Walking
- Bending
- Lying Down
- Getting in/out of car
- Pushing
- Pulling
- Dressing Self
- Bathing/Showering
- Stooing

