PATIENT INTRODUCTION FORM

Today's Date: _____

Last Name: **MI:** **First Name:**	
Home Address: **City:** **State:** **Zip:**	
Date Birth: Age:	Social Security Number:
Height: Weight:	**Who Referred You to Our Office**:
Employer's Name:	Marital Status (Circle): Single, Married, Divorced, Widowed
Occupation:	Name of Family Physician:

☐ **YES,** ☐ **NO I authorize the following telephone numbers** ☐ **YES,** ☐ **NO I authorize the use of my address for mailing** ☐ **YES,** ☐ **NO I authorize the use of my e-mail address** **Home:_____ Work _____** **Cell / Pager (Please circle to indicate): _____** **E-mail: _____** Indicate if you have a preferred mailing address: _____ _____ **Signature:_____ Date:_____** Expiration Date/Event for Authorization: ☐ No expiration date ☐When I have discontinued treatment and all bills have been paid. ☐ Date: _____	Our office needs to leave messages, return telephone calls, and send office mail to your home address as part of our normal practice. Federal/State Health Insurance Portability and Accountability Act (HIPAA) patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers that are acceptable for our office to call. Your agreement will allow our office to use your name and the indicated mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. We will use your home address, noted above, unless you indicate a preferred address. You may indicate a preferred mailing address by indicating so on this form. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

The HIPAA information has been provided to me by this office. _____
(Signature and date)

IS THIS VISIT RELATED TO:

☐ Work Related Injury/Symptoms
☐ Sport or Recreational Injury
☐ Motor Vehicle Crash Injury
☐ Motorcycle-Bicycle Injury
☐ Home Injury Symptoms
☐ Non-Injury Pain/Symptoms
☐ Other (Describe):_____
_____

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

_____

_____

I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health insurance carrier.

PATIENT SIGNATURE _____ DATE _____
(Minors must have parent's signature.)

Steve Eustice, D.C., C.Ad.(c) ***Spinal Health of North Texas Denton Texas 76209 www.spinalhealthofnorthtexas.com***
Phone: 940.591.9097 Fax 940.591.8384 **TX Lic: 6428**

Spinal Health of North Texas at Shambhala Wellness
Dr. Steven B. Eustice, D.C. C.Ad.(c)
www.SpinalHealthofNorthTexas.com

Name: _____ Date: _____

Email : _____

DOB: _____ Gender: _____ Preferred Language: _____

Race:

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Patient Declined to Provide

Ethnicity:

- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Patient Declined to Provide

Smoking Status:

- ○ Current Every Day Smoker
- ○ Current Some Day Smoker
- ○ Former Smoker
- ○ Never Smoker

Active Medications (If none/unknown, please specify):

_____
_____
_____

Medication Allergies (If none/unknown, please specify):

_____
_____
_____

Height:

Weight

Current Complaint/Diagnosis:

_____
_____
_____

Signature:

Spinal Health of North Texas at Shambhala Wellness
Dr. Steven B. Eustice, D.C. C.Ad.(c)
www.SpinalHealthofNorthTexas.com

Name: _____ Date: _____

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DOB: _____ Gender: _____ Preferred Language: _____

Race:

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Smoking Status:

- ○ Current Every Day Smoker
- ○ Current Some Day Smoker
- ○ Former Smoker
- ○ Never Smoker

Active Medications (If none/unknown, please specify):

_____
_____
_____

Medication Allergies (If none/unknown, please specify):

_____
_____
_____

Height:

Weight

Current Complaint/Diagnosis:

_____
_____
_____

Signature:

GENERAL HEALTH HISTORY

Name _____ **Date** _____

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	I bruise easily	☐	☐
☐	I heal slowly	☐	☐
☐	My body temperature is normally low (feel cold)*	☐	☐
☐	Smoke cigarettes or use tobacco products	☐	☐
☐	Diabetes, hypoglycemia, thyroid disorder, kidney or liver disease, or tuberculosis	☐	☐
☐	Heart attack or have a heart pacemaker or neck or chest shunt?	☐	☐
☐	Currently or recently had any disease such as AIDS, Tuberculosis, etc	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Do you have problems with dizziness, blacking out, balance, fainting, or tripping	☐	☐
☐	Epilepsy-Seizure-Convulsion history or other neurological disease	☐	☐
☐	History of multiple sclerosis, lupus, psoriasis, temporary paralysis, or meningitis	☐	☐
☐	Cancer history or cancer treatment of any type	☐	☐
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae	☐	☐
☐	Told that you have a bulging/herniated disc or disc degeneration	☐	☐
☐	Have you ever been hospitalized? Why:	☐	☐
☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm	☐	☐
☐	Hypertension or high blood pressure	☐	☐
☐	Told you have osteoporosis, osteopenia, or ankylosing spondylitis	☐	☐
☐	Told you have osteoarthritis, rheumatoid arthritis, or gout of your spine or joints	☐	☐
☐	Do you have any type of breast or pectoralis implants (applies to females & males)	☐	☐
☐	Women Only: Check this box if there is any chance that you are currently pregnant		

FAMILY HISTORY

(☐ I have no family history of these conditions) If you have family history of these conditions, please check below:

	Heart Disease	Arthritis	Cancer	Diabetes	Other: _____
Father's Side	☐	☐	☐	☐	☐
Mothers's Side	☐	☐	☐	☐	☐

PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

(☐ I have no history of previous painful injury or pain) If you have had prior injuries or pain, please check below:

☐ Work Injury	☐ Fall	☐ Sports Injury	☐ Lifting Injury	☐ Car accident
☐ Motorcycle Injury	☐ Head Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches/Migraines	☐ Neck Pain/Arm Pain	☐ Middle Back Pain	☐ Low Back/Leg Pain	☐ Other Pain

FRACTURES/BROKEN BONES

(☐ I have never had any broken bones). If you have broken any bones, indicate where and when below:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib bone	
☐ Arm or hand bone		☐ Leg or foot bone	
☐ Pelvis or hip bones		☐ Other	

PREVIOUS SURGERIES

(☐ I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck, back, or pelvis)		☐ Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Tonsillectomy		☐ Rib/Collar bone	
☐ Head/Brain		☐ Hernia	
☐ Shoulder/Arm/Hip/Leg		☐ Other	

GENERAL HEALTH HISTORY

Name _____ **Date**_____

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
☐ Headaches/Migraines		☐ Upper Back Pain, Soreness, or Stiffness	
☐ Neck Pain, Soreness, or Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, Stiffness		☐ Leg or Foot Pain, Numbness, or Tingling	
☐ Arm/Hand Pain, Numbness, or Tingling		☐ Other:	

Did your symptoms come on ☐ Suddenly ☐ Gradually

SYMPTOM/PAIN DESCRIPTION

Please circle any word or all words below that best describes how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

Have you ever been to a Chiropractor before for any condition?

☐ No ☐ Yes If yes, Chiropractor's Name : _____ Year:_____

Condition/Problem: _____

Do you have any problems laying face down on an examination table?

☐ No ☐ Yes If yes, why: _____

ARE YOU TAKING ANY MEDICATIONS?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

	☐ Blood pressure/Stroke prevention medications	☐ Cortisone injections
☐ Pain/Anti-inflammatory meds	☐ Osteoporosis (bone strengthening) medications	☐ Other:

WHEN IS PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN LEVELS?

☐ Morning is when pain is worse	☐ Bending your back increases pain	☐ Walking increases pain
☐ Afternoon/evening pain worse	☐ Lying down flat increases pain	☐ Standing increases pain
☐ During sleep hours pain worse	☐ Sitting increases pain	☐ Exercise/Stretching increases pain
☐ Standing up from sitting	☐ Poor posture increases pain	☐ Other:

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

DO YOU EXERCISE?

☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting at gym/home	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I am not willing to do exercises	☐ I do regular sports activities

Spinal Health of North Texas
Life Style Factors of Vitamin/Mineral Defficiency

Name:_____ Date:_____

Circle your answer

Yes/No 1. On average, do you eat fewer than five fruit and vegetable servings per day?

Yes/No 2. Do you experience a scaly, flaky seborrheic condition at the outer nose margins above the lips?

Yes/No 3. Do you have soft nails or nails that chip, crack, or peel easily, and/or are brittle or contain ridges (rather than being smooth)?

Yes/No 4. Are there white spots under your fingernails?

Yes/No 5. Have you noticed small red spots under your skin?

Yes/No 6. On average, do you consume more than three alcoholic beverages per week?

Yes/No 7. On average, do you drink more than two cups of coffee or caffeinated tea (of any kind) per day?

Yes/No 8. Are you a smoker?

Yes/No 9. Has your skin been damaged by sunlight and/or do you use a tanning bed more than once per month?

Yes/No 10. On a scale of one to five, is the daily stress level in your life three or greater, if one is low stress and five is high stress?

Yes/No 11. Do you often experience cracks at the margins of your lips?

Yes/No 12. Do you experience a sore or burning tongue?

Yes/No 13. Have you experienced a reduced ability to taste food?

Yes/No 14. Do your gums bleed easily?

Yes/No 15. Do you bruise easily?

Yes/No 16. Are you a slow healer from bruises and cuts?

Yes/No 17. Do you feel chronically tired?

Yes/No 18. Do you have irregular eating patterns?

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Spinal Health of North Texas
Life Style Factors of Vitamin/Mineral Defficiency

Name:_____ Date:_____

Yes/No 19. Are you on a weight-loss or calorie-restricted diet?

Yes/No 20. Do you feel run down and/or experiencing a weakened state of immunity?

Yes/No 21. Does your hair fall out easily, and/or is it dry and brittle and/or does it lack optimal luster and sheen?

Vitamin/Mineral Depletion from Medications

Do you regularly use any of the following medications or agents?
Circle your answer.

Yes/No 1. Laxatives

Yes/No 2. Long-term antibiotic therapy

Yes/No 3. Cholesterol lowering drugs: Cholestyramine, Colestipol, Questran, Colestid, Atrmid-S

Yes/No 4. Anti-gout drug Colchicine

Yes/No 5. Steroid hormones: cortisone, prednisone, etc….

Yes/No 6. Aspirins for arthritis or any other reason (or other nonsteroidal anti-inflammatory drugs: ibuprofen, naproxen, etc…)

Yes/No 7. Antacids: Maalox, Tums, Mylanta, Rolaids, Diovol, etc…

Yes/No 8. Oral contraceptives

Yes/No 9. Sedatives/barbituates: Phenobarbitol, Fiorinal, Phenaphen, Atropine, etc…

Yes/No 10. Estrogen replacement drugs.

Yes/No 11. Caffeine: coffee, tea, espresso, etc…

Yes/No 12. Smoking

Yes/No 13. Antidepressants: Prozac, Paxil, Zoloft, Celexa, Amitryptyline, etc…

Yes/No 14. Amphetimines: Adderall, Cylert, Ritalin, Benedrine, Dexedrine, etc…

Spinal Health of North Texas
Life Style Factors of Vitamin/Mineral Defficiency

Name:_____ Date:_____

Yes/No 15. Levodopa

Yes/No 16. Anticonvulsants: Dilantin, Celontin, Zorontin, Carbamazepine, Phenobarbital, etc…

Yes/No 17. Heart medications: digoxin or digitalis.

Yes/No 18. Inflammation/pain medications: indomethacin

Yes/No 19. Diuretics: Thiazide drugs, Hydrochorothizide, Moderet, Aptrizide, Midamor, etc…

Yes/No 20. High blood pressure, ACE inhibitor drugs: Captopril, Capoten, Lotensin, Vasotec, Ramipril, Altace, Prinivil

Yes/No 21. High blood pressure beta blockers: Atenolol, Metoprolo, Propraolol, Acebutolol

Yes/No 22. High cholesterol, statin drugs: Crestor, Mevacor, Zocor, Lescol, Pravachol

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Assignment of Benefits and Authorization

While Spinal Health of North Texas is waiting for payment for all of the fees, I agree to provide the office with information and forms regarding any source of potential payment, to assist in any way I can, and:

1. I hereby assign (practice) my rights to receive payments from the insurance companies responsible for my claim.
2. I also hereby authorize the direct payment to (practice) of any sum I now or hereafter owe by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. You are authorized to release any information including the diagnosis and records of any such treatment to any insurance company to process any claims for reimbursement of charges incurred.
4. I hereby assign and transfer to you the cause of action that exists in my favor, including the right to proceed via state external appeal or Superior Court, against the insurance company, responsible for this claim to collect any unpaid bills.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

_____

Patient's Signature

_____

Date

Spinal Health of North Texas
Steve Eustice DC

Authorization to Use or Disclose Protected Health Information and Consent to Treatment

Your authorization is requested for purposes of delivering your care in an open-door environment as described in the office's privacy notice.

In the course of your care, in this environment, routine details of your condition and care may be disclosed to other patients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other patients.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver treatment. Your care will not be conditioned on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization at a later date if that is your wish. If you wish to revoke this authorization at some time in the future please advise us accordingly in writing. You always have the right to review our most updated PHI information. You can also contact our privacy officer at 940-591-9097

Additionally, you are consenting to treatment by the above named provider(s). You understand that results are not guaranteed and are partly based on my cooperation with receiving the recommended care. You also will hold harmless, any complications of treatment, regardless of how rare complications may occur. You also agree, you have discussed your care with our provider and understand the treatment that will be rendered to you.

If you agree to this authorization and have received and reviewed our office's HIPAA privacy notice please sign and date below. A copy of this authorization will be maintained by this office.

Thank you for your cooperation and understanding.

Name: _____
Signature: _____ Date: _____

If you are a minor or if you are being represented by another party please provide the appropriate person's:
Name: _____
Signature: _____ Date: _____
Relationship to the patient: _____