Lionheart
SERIOUS INTEGRATIVE HEALTHCARE

We would like to welcome you and thank you for selecting our team. We are committed to provide you with the best possible health care. To help us assess your current health care needs, we would like you to complete the following forms. We know we are asking you many questions, but we feel it is important that you take the time to complete all pages. Many of our patients have seen several other healthcare providers and continue to experience ongoing medical problems. Our comprehensive questionnaires really help us to determine the best diagnosis and treatment plan.

If you have any questions or need assistance, please feel free to ask us. Of course, all information becomes part of your medical record and it is strictly confidential.

Demographics

Name:_____ DOB:_____ Sex: M F

Address: _____

Cell Phone: _____ Home Phone: _____

Work Phone:_____ Email: _____

Emergency Contact: _____ Phone: _____

Employer Name: _____ Phone: _____

Primary Care Physician:_____ Phone:_____

Pharmacy Information

Name:_____Phone:_____

Address:_____

Compounding Pharmacy Name: _____

Phone:_____Address:_____

Primary Insurance Information

(For patients who are covered by health insurance and want to use it on general labs drawn here in the clinic)

Insurance Company Name: _____

Policy ID Number: _____

Referred By_____

(We would like to personally thank your referrer!)

Lionheart | Dr. Elizabeth Eversull
17300 Preston Road Suite 160 Dallas, TX 75252
Office: 469-726-2737 Fax: 972-612-5048

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Office Policies

Deposit for First Visit: In order to avoid new patients failing to show up for their initial appointment, we charge your credit card $200.00 when the appointment is booked. This acts as a deposit towards the initial $600.00 visit.

Cancellations: If you call to cancel or reschedule an appointment within 24 hours of the appointment or arrive over 10 minutes late for your appointment, a $200.00 fee will be charged/you may be rescheduled.

Missed Appointments: Patients who schedule an appointment but fail to show up, are documented as "NO SHOW" and will be charged a $100 fee due immediately. I understand that if I have three no-show appointments, I may be dismissed from the practice. If you schedule an IV and no show you will be charged for the entire price of the IV. **Once the IV is drawn up, you are responsible for the payment. No exceptions.**

Prescriptions: Please allow 24 hours for processing all prescription requests. Walk-in refill requests are not permitted.

Payment: Payment is expected at the time of service. Your initial appointment is $600 (1 hour), follow up appointments are $250 (30 min). Patients unable to make a payment at the time of service will be rescheduled. Accepted methods of payment include cash, debit or credit card. Any balances not collected at time of service are the patient's responsibility.

Returns: We will accept returns of unopened unsoiled items within 14 days of purchase, for store credit, at the discretion of the practice. Injectables and tinctures **WILL NOT** be accepted for returns.

Form Completion: There is a charge for paperwork according to time. This includes paperwork, writing letters, reports or filling out forms. Please fill out anything you can before submitting to us to lessen your cost. Please allow up to 14 business days to complete all medical forms.

Medical Records: The minimum fee of $25 for the first 20 pages and an additional $0.75 per page thereafter. If requested by a doctor, there is no charge. An authorization for release must be signed and submitted before any request will be processed for any requesting parties. Please allow up to 14 business days for charts to be processed and sent/released.

Patient Name**:** _____ Date**:**_____

Signature**:** _____
(Your signature signifies that you have read, understand, and agree to our policies.)

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HIPAA POLICY ACKNOWLEDGEMENT

I understand that I have rights regarding my protected health information. These rights are Governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have been informed of and given the opportunity to review and secure a copy of Elizabeth Eversull, MD Notice of Privacy Practices, which contains a complete description of the uses and disclosure of my protected health information.

I understand that The Notice of Privacy Practices information serves as:

- A basis for planning my care and treatment.
- A means of communication amongst the healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were provided.
- A tool for routine healthcare operations, such as assessing care quality and reviewing the competence of healthcare professionals.

Please provide the following methods where we can reach you and whether a message may be left.

Home Phone:_____ Detailed Message? YES NO

Work Phone: _____ Detailed Message? YES NO

Cell Phone: _____ Detailed Message? YES NO

Texts may be sent to my cell phone for appointment confirmations: YES NO

Email:_____ Detailed Message? YES NO

Would you like to sign up for Dr. Eversull's email list? YES NO

I authorize my medical information to be discussed/ disclosed to:

Name:_____ Relationship: _____

Name:_____ Relationship**:**_____

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practice for Elizabeth Eversull, MD./Handmade Health

Patient Name (Print):_____ Date: _____

Patient Signature:_____ Date: _____

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Name: _____ DOB: _____Date:_____

Main reason for visit: _____
Secondary reason: _____
Other issues you want to work on (if any): _____
_____

History of what is going on, when it began, and what have you tried to improve it:

_____
_____
_____
_____
_____
_____

What worked the best, if anything? _____

All Medical Problems/ Diagnoses	Treatments

Surgeries	Dates

Medications	Dose	Frequency

Allergies	Reaction

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Nutrition + Gut Health Name: _____ DOB: _____

Supplements	How Many	How Often

Sample Daily Diet *(Try Hard Here!)*

Day 1

Time	Food	Time	Food

Day 2

Time	Food	Time	Food

I Crave_____ I Avoid _____

Weekly Servings of	Weekly Amount
Cups of coffee	
Alcoholic beverages	
Number of restaurant meals	
% of food intake that is organic, non-GMO	
Corn based foods	
Sugary foods	
Peanuts/ peanut butter	
Aged cheese	
Mushrooms	
Sushi	
Diet drinks	
Wine	

Characterize Stool: *Circle below*

Brown Green Tan Painful Black Bloody
Loose Stringy Foamy Hard/Pellet-Like Undigested Food Floats in Toilet
Bowel movements: _____ Per day/week

Were you breast fed? (Y N) If so, for how long? _____ Born by c-section or vaginal delivery?
What was your maximum weight? _____ What is your current weight? _____ Height_____

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Name: _____ DOB: _____

Thinking over the last 4 weeks, rate the following symptoms 0-4. With 0 meaning you are completely free of issue and 4 meaning you suffer significantly and frequently.

Detoxification Questionnaire

HEAD _____ Headaches _____ Faintness _____ Dizziness _____ Insomnia **Total: _____**	**HEART** _____ Chest pain _____ Irregular/skipped heartbeat _____ Rapid/pounding heartbeat **Total: ____**	**ENERGY** _____ Fatigue/sluggishness _____ Apathy/lethargy _____ Hyperactivity _____ Restlessness **Total: _____**
EYES _____ Itchy eyes _____ Swollen or stick eyelids _____ Bags/dark circles _____ Blurred/altered vision **Total: _____**	**Skin** _____ Acne _____ Hives/rashes/dry skin _____ Hair loss _____ Flushing/hot flashes _____ Excessive sweating **Total: ____**	**HEAD** _____ Headaches _____ Faintness _____ Dizziness _____ Insomnia **Total: _____**
EARS _____ Itchy ears _____ Earaches/ear infections _____ Drainage from ear _____ Ringing in ears/hearing loss **Total: _____**	**LUNGS** _____ Chest congestion _____ Asthma/bronchitis _____ Shortness of breath _____ Difficulty breathing **Total: _____**	**EMOTIONS** _____ Mood swings _____ Anxiety/fear/nervousness _____ Anger/irritability/aggressiveness _____ Depression **Total: _____**
NOSE _____ Stuffy nose _____ Sinus problems _____ Hay fever _____ Sneezing attacks _____ Excessive mucus **Total: _____**	**DIGESTIVE** _____ Nausea/vomiting _____ Diarrhea _____ Heartburn _____ Intestinal/stomach pain _____ Constipation _____ Bloating _____ Belching/passing gas **Total: _____**	**MIND** _____ Poor memory _____ Confusion/poor comprehension _____ Difficulty making decisions _____ Stuttering or stammering _____ Slurred speech _____ Learning disabilities _____ Poor concentration _____ Poor coordination **Total: _____**
MOUTH/THROAT _____ Chronic coughing _____ Gagging/throat clearing _____ Sore throat/hoarseness _____ Swollen/discolored tongue/lip _____ Canker sores **Total: _____**	**JOINTS/MUSCLE** _____ Pain or aches in joints _____ Arthritis _____ Stiffness/limited movement _____ Feeling weak/tired _____ Pain or aches in muscles **Total: _____**	**WEIGHT** _____ Binge eating _____ Craving certain foods _____ Excessive weight _____ Water retention _____ Underweight _____ Compulsive eating **Total: _____**
		GRAND TOTAL: _____

Are you very sensitive to fragrances, dyes, or chemicals? _____
Do you have an excessive reaction to caffeine or alcohol? _____

Comments:
_____
_____

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Name:_____ DOB:_____

Social History	
Relationship status: **S / M / D / W** Is your spouse healthy? **Yes / No** Do you have children? **Yes / No** Are your children healthy? **Yes / No**	Do you exercise? **Yes / No** How often? _____ Cardio? **Yes / No** Weights? **Yes / No** Other exercise: _____
Current occupation _____ Describe your work _____ _____ _____ Prior occupation(s) _____	Are you a smoker? **Yes / Former/ Never smoker** If yes, how many cigs per day? _____ per day How long have you/did you smoke? _____ years If you quit, when did you quit? _____ Other substances used: _____
Where do you primarily live? _____ Where did you grow up? _____ Other places you have lived: _____ How often do you travel? _____	History of abuse? Physical: **Yes / No** Emotional: **Yes / No** Sexual: **Yes / No** Verbal: **Yes / No** Was the abuse during childhood or as an adult?_____ Any additional info:_____

Exposures	
<u>Vaccines you have had</u>: (circle from the list below) **Childhood Hepatitis Travel Flu Lyme Military** List and describe any reactions to vaccines: _____ _____ _____	**<u>Have you had</u>**: Food poisoning? How many times?_____ Parasite infections? What type?_____ IBS/Chronic constipation? **Yes / No** IBS/Chronic diarrhea? **Yes / No** Ear infections? How many times?_____ Sinus infections? How many times?_____ UTIs? How many times?_____ Strep? How many times?_____ Bronchitis? How many times?_____ Pneumonia? How many times?_____
Ever been bitten by a tick or spider? **Yes / No** If so, please list and date: _____ Have you ever lived in a building with mold? **Yes / No** Have you ever worked in a building with mold? **Yes / No** Has your home/workplace/car ever flooded? **Yes / No** Has your home/work/car had a water leak? **Yes / No** If so, please describe: _____ _____	**<u>Estimate the number of time you used/had:</u>** Oral antibiotics How many?_____ IV antibiotic How many?_____ Metal fillings (teeth) How many?_____ Metal fillings removed How many?_____ Root canals How many?_____ Other dental work: _____ _____

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Name: _____ DOB: _____

Family history	Alive/deceased	Medical issues
Father		
Mother		
Maternal Grandfather		
Maternal Grandmother		
Paternal Grandfather		
Paternal Grandmother		
Siblings:		
Siblings:		
Siblings:		
Siblings:		

Females

Age of first menses _____ years of age
Are you still cycling? **Yes / No**
Regular number of days _____
Irregular number of days _____
Age of menopause ____ years of age

Comment:_____
_____

History of Hormone Replacement? **Yes / No**
If so, what age(s)? _____

What were your goals with hormones?_____

Have you ever used birth control pills? **Yes / No**
If so, when and for how long? _____
_____

Number of:
Total pregnancies _____ Living children_____
Full-term pregnancies _____ Miscarriages _____
Preterm pregnancies _____ Abortions _____

History of irregular menses? **Yes / No**
History of abnormal pap smear? **Yes / No**
History of fertility drugs? **Yes / No**
History of PCOS? **Yes / No**
History of endometriosis ? **Yes / No**
History of abnormal mammogram? **Yes / No**
History of fibroids? **Yes / No**
History of mesh placement ? **Yes / No**

Additional comments:

Health Maintenance

Do you get yearly or semi-yearly screenings on the following?

Prostate exam **Yes / No** Breast ultrasound **Yes / No** Pap smear **Yes / No**
Mammogram **Yes / No** Coronary artery calcium score **Yes / No**

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Constitutional	Yes	No	**Cardiovascular**	Yes	No	**Dermatologic**	Yes	No
fever			chest pain			change in nails		
night sweats			palpitations			dry hair		
chills			varicose veins			hair loss		
cold intolerance			edema in legs			dry skin		
fatigue						itching		
daytime sleepiness			**Breast**			hives		
weight gain			breast lump			rash		
weight loss			breast pain			bruising		
change in appetite			nipple discharge			new mole		
						skin sores		
Eyes			**Gastrointestinal**					
change in vision			abdominal pain			**Musculoskeletal**		
eye redness			rectal pain			muscle pain		
eye pain			nausea			back pain		
tearing			vomiting			muscle cramps		
			vomiting blood			muscle weakness		
Ears			bloating			less muscle strength		
difficulty hearing			excess gas			difficulty walking		
ear pain/earache			constipation					
ringing in ears			increased frequency of BM			**Neurologic**		
			diarrhea			headaches,		
Nose			fecal incontinence			dizziness		
nasal congestion			clay-colored stools			lightheadedness		
runny nose			greasy stools			fainting		
nose bleeds			tarry stools			numbness		
sneezing						tingling		
snoring			**Urinary**			tremor		
			painful urination			lack of coordination		
Mouth			blood in urine			weakness		
oral sores			urinary hesitancy			difficulty speaking		
sore throat			urine dribbling			memory loss		
dysphagia			urine frequency			difficulty concentrating		
gum bleeding			decreased urination					
dental problems			waking to urinate			**Psychiatric**		
hoarse voice			incontinence			change in mood		
			incontinence with cough			depression		
Neck						suicidal ideation		
neck pain			**Genital/Reproductive**			anxiety		
neck stiffness			change in libido			nervousness		
neck lumps			problems w/ sexual function			sleep disturbance		
neck swelling			menstruating			hallucination		
			menopause					
Respiratory			pain with cycle			**Blood/Lymph**		
shortness of breath			irregular cycles			easy bruising		
cough			last cycle date:			difficulty stopping bleeding		
wheezing			vaginal bleeding			large lymph nodes		
			hot flashes			tender lymph nodes		
			genital discharge					

Expand on any of the above:

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