

Full Motion Integrated Medicine

4815 1st St N, Arlington, VA 22203

Patient Name _____ Date: _____ Email: _____

SS #/SIN _____ DOB _____ Home phone _____ Cell Phone _____

What is your gender: Female Male Non-binary Transgender I prefer not to say

Check appropriate Box: Minor Single Married Divorced Widowed Separated

Patient's Address _____ City _____ State _____ Zip _____

Employer Name: _____

Spouse or Patient's Guardian name _____ Spouse's Employer _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence.

Parent or Guardian _____ Date _____

Responsible Party

Name of The Person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

E-Mail _____ Cell Phone _____

Driver's License # _____ Date of Birth: _____

Is the person currently a patient at our office? Yes No

Do you have any Medical insurance? Yes No If yes, please complete the following:

Name of the insured _____ Relationship to patient _____

Birthdate _____ SS#/SIN _____ Name of Employer _____ Work Phone _____

Address of Employer _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **FULL MOTION INTEGRATED MEDICINE** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 _____.

X _____ (SEAL)
(patient signature)

X _____ (SEAL)
(signature of Guardian if applicable)

X _____
(please print patient name)

Health History

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint: _____

History of Present illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: normal vs abnormal color, activity, etc..)

Severity: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____
(How long have you had this pain/problem? When did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____

Modifying Factors _____

(What other associated problems have you been having?)

(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no" / leave blank if you are uncertain.)

| | | | |
|----------------------------|------------------------------|----------------------------------|------------------------------|
| Measles.....NO YES | Anemia.....NO YES | Back Trouble.....NO YES | Hepatitis.....NO YES |
| Mumps.....NO YES | Bladder Infection.....NO YES | High Blood Pressure.....NO YES | Ulcer.....NO YES |
| Chicken Pox.....NO YES | Epilepsy.....NO YES | Low Blood Pressure.....NO YES | Kidney Disease.....NO YES |
| Whooping Cough.....NO YES | Migraine Headaches...NO YES | Hemorrhoids.....NO YES | Thyroid Disease.....NO YES |
| Scarlet Fever.....NO YES | Tuberculosis.....NO YES | Date of Last Chest X-Ray_____ | Bleeding Tendency.....NO YES |
| Diphtheria.....NO YES | Diabetes.....NO YES | Asthma.....NO YES | Any Other Disease.....NO YES |
| Smallpox.....NO YES | Cancer.....NO YES | Hives of Eczema.....NO YES | (Please List): |
| Pneumonia.....NO YES | Polio.....NO YES | AIDS & HIV.....NO YES | _____ |
| Rheumatic Fever.....NO YES | Glaucoma.....NO YES | Infectious Mono.....NO YES | _____ |
| Arthritis.....NO YES | Hernia.....NO YES | Bronchitis.....NO YES | |
| Venereal Disease....NO YES | Blood or Plasma | Mitral Valve Prolapse.....NO YES | |
| | Transfusion.....NO YES | Stroke.....NO YES | |

| Previous Hospitalizations/Surgeries/Serious Illnesses | When? | Hospital, City, State |
|---|-------|-----------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Medication: (include nonprescription)

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion? NO YES

If yes, what type: _____

Patient Social History:

Use of Alcohol Never Rarely Moderate Daily

Use of Tobacco Never Rarely Moderate Daily

Use of Drugs Never Yes, in the past or now. Type/Frequency: _____

Excessive Exposure At home or at work to: Fumes Dust Solvents Noise Airborne Particles

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:** _____

Patient Name: _____ DOB: _____ Date: _____

Family Medical History:

| | Age | Disease | If Deceased, Cause of Death |
|-----------|-------|---------|-----------------------------|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Spouse: | _____ | _____ | _____ |
| Children: | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

Indicate which of the below you have experienced in the last 1-2 months:

1 = Never 2 = Rarely 3 = Occasionally 4 = Frequently 5 = Constantly

Eyes/Ears/Nose/Throat/Respiratory

| | | | | | |
|--------------------------|---|---|---|---|---|
| Asthma | 1 | 2 | 3 | 4 | 5 |
| Stuffy Nose | 1 | 2 | 3 | 4 | 5 |
| Hay Fever | 1 | 2 | 3 | 4 | 5 |
| Sore throat | 1 | 2 | 3 | 4 | 5 |
| Chronic Cough | 1 | 2 | 3 | 4 | 5 |
| Chest Congestion | 1 | 2 | 3 | 4 | 5 |
| Frequent Sneezing | 1 | 2 | 3 | 4 | 5 |
| Itchy/Watery Eyes | 1 | 2 | 3 | 4 | 5 |
| Drainage | 1 | 2 | 3 | 4 | 5 |
| Earache or Ear Infection | 1 | 2 | 3 | 4 | 5 |
| Itching | 1 | 2 | 3 | 4 | 5 |
| Hoarseness | 1 | 2 | 3 | 4 | 5 |
| Shortness of Breath | 1 | 2 | 3 | 4 | 5 |
| Wheezing | 1 | 2 | 3 | 4 | 5 |

Muscular/Skeletal

| | | | | | |
|--------------------------|---|---|---|---|---|
| Muscle Aches | 1 | 2 | 3 | 4 | 5 |
| Fibromyalgia | 1 | 2 | 3 | 4 | 5 |
| Arthritis | 1 | 2 | 3 | 4 | 5 |
| Joint Pain | 1 | 2 | 3 | 4 | 5 |
| Low Back Pain | 1 | 2 | 3 | 4 | 5 |
| Neck Pain | 1 | 2 | 3 | 4 | 5 |
| Wrist/Hand Pain | 1 | 2 | 3 | 4 | 5 |
| Elbow Pain | 1 | 2 | 3 | 4 | 5 |
| Shoulder Pain | 1 | 2 | 3 | 4 | 5 |
| Hip Pain | 1 | 2 | 3 | 4 | 5 |
| Knee Pain | 1 | 2 | 3 | 4 | 5 |
| Ankle/Foot Pain | 1 | 2 | 3 | 4 | 5 |
| Pain b/t shoulder blades | 1 | 2 | 3 | 4 | 5 |

Neurological

| | | | | | |
|-------------------------------|---|---|---|---|---|
| Headaches | 1 | 2 | 3 | 4 | 5 |
| Migraines | 1 | 2 | 3 | 4 | 5 |
| Dizziness | 1 | 2 | 3 | 4 | 5 |
| Numbness | 1 | 2 | 3 | 4 | 5 |
| Tingling | 1 | 2 | 3 | 4 | 5 |
| Pins/needles in hands or feet | 1 | 2 | 3 | 4 | 5 |

General

| | | | | | |
|---------------------|---|---|---|---|---|
| Fatigue | 1 | 2 | 3 | 4 | 5 |
| Malaise | 1 | 2 | 3 | 4 | 5 |
| Weakness, tiredness | 1 | 2 | 3 | 4 | 5 |
| Lightheadedness | 1 | 2 | 3 | 4 | 5 |
| Irritability | 1 | 2 | 3 | 4 | 5 |
| Constipation | 1 | 2 | 3 | 4 | 5 |
| Diarrhea | 1 | 2 | 3 | 4 | 5 |
| Feeling foggy | 1 | 2 | 3 | 4 | 5 |
| Forgetfulness | 1 | 2 | 3 | 4 | 5 |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of the Patient, Parent or Guardian

Date

Doctor's Review

Signature of Doctor

Date