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 or 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) (please print patient name)

Health History – *Please help our providers by completing this form in its entirety*.

Patient Name:____ DOB:________________ Date:_________________

Chief Complaint: ____

History of Present illness:

Location: ____
(Where are you having pain?)

Quality: ____
(What does the pain feel like? Ex: sharp, dull, aching, burning, etc.)

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

Duration: ____
*(When is the very **first time** you felt this pain? Ex: 2 years ago)*

Timing: ____
(What time of day is your pain the worst?)

Context: ____
(Is there a specific incident that started this pain?)

Associated Signs/Symptoms ___________________________

____
(What other associated problems have you been having?)

Modifying Factors ___________________________________

____
(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.)

Diabetes……………....NO YES
Bleeding Tendency..NO YES
Measles…………………NO YES
Mumps…………………NO YES
Scarlet Fever…………NO YES
Diphtheria……………NO YES
Smallpox………………NO YES
Pneumonia……………NO YES
Rheumatic Fever……NO YES
Arthritis………………NO YES
Venereal Disease…..NO YES
Chicken Pox…………NO YES

Anemia……………………NO YES
Bladder Infection………NO YES
Epilepsy……………………NO YES
Migraine Headaches…NO YES
Tuberculosis……………NO YES
Stroke………………………NO YES
Cancer………………………NO YES
Polio…………………………NO YES
Glaucoma…………………NO YES
Hernia………………………NO YES
Blood or Plasma
Transfusion………………NO YES

Back Trouble………………NO YES
High Blood Pressure…….NO YES
Low Blood Pressure……..NO YES
Hemorrhoids………………NO YES
Date of Last Chest X-Ray____________
Asthma………………………NO YES
Hives of Eczema…………NO YES
AIDS & HIV…………………NO YES
Infectious Mono…………NO YES
Bronchitis…………………NO YES
Mitral Valve Prolapse……NO YES

Hepatitis……………………NO YES
Ulcer…………………………NO YES
Kidney Disease……………NO YES
Thyroid Disease…………NO YES
Whooping Cough………NO YES
Any Other Disease………NO YES
(Please List):

____

____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________

Medication: (include nonprescription)

____
____

Medication Allergies:

____
____

Do you take any steroid medications? ☐ NO ☐ YES
If yes, what type: ____
Do you use an asthma inhaler? ☐ NO ☐ YES
Are you allergic to Sulfa? ☐ NO ☐ YES

Women under 55:
Date of LMP:________________________
Date of Hysterectomy:________________
Date of Onset of Menopause:___________
Date of Tubal Ligation:________________

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

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

Muscular/Skeletal

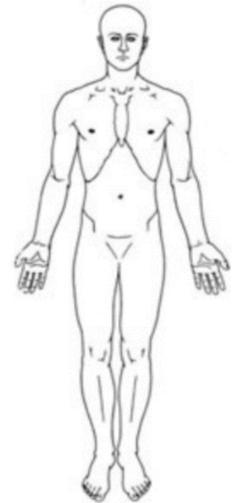
Muscle Aches	1	2	3	4	5
Fibromyalgia	1	2	3	4	5
Arthritis	1	2	3	4	5
Joint Pain	1	2	3	4	5
Low Back Pain	1	2	3	4	5
Neck Pain	1	2	3	4	5
Wrist/Hand Pain	1	2	3	4	5
Elbow Pain	1	2	3	4	5
Shoulder Pain	1	2	3	4	5
Hip Pain	1	2	3	4	5
Knee Pain	1	2	3	4	5
Ankle/Foot Pain	1	2	3	4	5
Pain between shoulder blades	1	2	3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

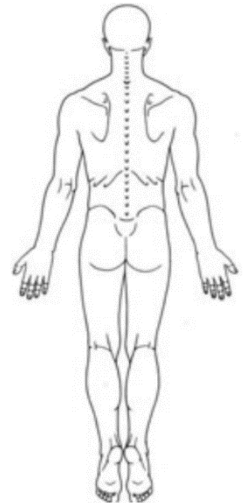
General

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

Graphically indicate areas of pain below:

(**CIRCLE** areas or mark with **X's**)





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

____ ____________________

Signature of **Clinician** Date