Full Motion Integrated Medicine – *Patient Intake Form*

Clinician Initials:_____
Review Date:_____

Patient Name:_____ DOB:_____ Date:_____

SS #:_____ Cell Phone:_____ Home Phone:_____ Email:_____

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 Code:_____

Employer Name:_____ Job Title:_____

Spouse Name:_____ Patient's Guardian (if applicable):_____

Whom may we thank for referring you:_____

Person to contact in case of an emergency:_____ Phone:_____

If the patient is of school age 15+ and there is a medical emergency, it is ok to treat the patient in my absence.

_____ _____
Parent or Guardian Signature Date

Responsible Party (If someone other than the Patient)

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

Address:_____

Cell Phone:_____ Home Phone:_____ E-Mail:_____

Driver's License #:_____ Date of Birth:_____

Medical Insurance (If you have insurance, please complete the fields below)

Name of Primary Insured:_____ Relationship to Patient:_____

DOB:_____ SS #:_____ Name of Employer:_____ Work Phone:_____

Address of Employer:_____ City:_____ State:_____ Zip Code:_____

Insurance Company:_____ Group #:_____ Union or local #:_____

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

IMPORTANT INFORMATION

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

Chief Complaint:_____

History of Present Complaint:

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, 10 being 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 past episodes?)

Patient Name:_____ DOB:_____ Date:_____

Clinician Initials:_____
Review Date:_____

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
Hepatitis---------- 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
Ulcer---------- NO YES
Asthma---------- NO YES
Hives or Eczema---------- NO YES
AIDS & HIV---------- NO YES
Infectious Mono---------- NO YES
Bronchitis---------- NO YES
Mitral Valve Prolapse------ NO YES

Kidney Disease---------- NO YES
Thyroid Disease---------- NO YES
Whooping Cough---------- NO YES
Cancer---------- NO YES
If yes, what type:_____
Any Other Disease---------- NO YES
If yes, please describe:_____
_____
_____
Date of Last X-Ray:_____
_____

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

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medication: (include nonprescription; if more space is needed, please use back of this sheet)

_____
_____

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 ☐NOT SURE

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

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Previous to Current Pain & Symptoms

Indicate which of the below you have experienced in the last 3 months:

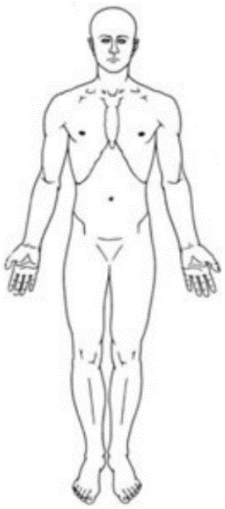
1 = Never 2 = Rarely 3 = Occasionally 4 = Frequently 5 = Constantly

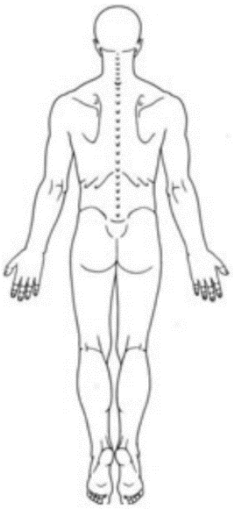
Eyes/Ears/Nose/Throat/Respiratory						**Muscular/Skeletal**					
Asthma	1	2	3	4	5	Muscle Aches	1	2	3	4	5
Stuffy Nose	1	2	3	4	5	Fibromyalgia	1	2	3	4	5
Hay Fever	1	2	3	4	5	Arthritis	1	2	3	4	5
Sore throat	1	2	3	4	5	Joint Pain	1	2	3	4	5
Chronic Cough	1	2	3	4	5	Low Back Pain	1	2	3	4	5
Chest Congestion	1	2	3	4	5	Neck Pain	1	2	3	4	5
Frequent Sneezing	1	2	3	4	5	Wrist/Hand Pain	1	2	3	4	5
Itchy/Watery Eyes	1	2	3	4	5	Elbow Pain	1	2	3	4	5
Drainage	1	2	3	4	5	Shoulder Pain	1	2	3	4	5
Earache or Ear Infection	1	2	3	4	5	Hip Pain	1	2	3	4	5
Itching	1	2	3	4	5	Knee Pain	1	2	3	4	5
Hoarseness	1	2	3	4	5	Ankle/Foot Pain	1	2	3	4	5
Shortness of Breath	1	2	3	4	5	Pain btw. shoulder blades	1	2	3	4	5
Wheezing	1	2	3	4	5						

Neurological						**General**					
Headaches	1	2	3	4	5	Fatigue	1	2	3	4	5
Migraines	1	2	3	4	5	Malaise	1	2	3	4	5
Dizziness	1	2	3	4	5	Weakness, tiredness	1	2	3	4	5
Numbness	1	2	3	4	5	Lightheadedness	1	2	3	4	5
Tingling	1	2	3	4	5	Irritability	1	2	3	4	5
Pins/needles in hands	1	2	3	4	5	Constipation	1	2	3	4	5
Pins/needles in feet	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 your 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

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_____
(patient signature)

X_____
(signature of Guardian if applicable)

_____
(please print patient name)

FULL MOTION INTEGRATED MEDICINE

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other ancillary procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or other licensed providers who now or in the future work at the clinic or office.

I will have the opportunity to discuss with the doctor(s) the nature and purpose of chiropractic adjustments and any other prescribed procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic and physical therapy there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

Non-surgical Decompression: muscle soreness, aching, spasms, numbness, and tingling sensations. Lumbar Decompression should not be used in patients who have had spinal fusion surgery or who are or may be pregnant. If Decompression is one of your prescribed therapies, you will receive additional information related to benefits & risks.

I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor(s) to exercise judgment during the course of the procedure which the doctor(s) feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that the doctor(s) will also explain the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name:_____

Patient/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Full Motion
INTEGRATED MEDICINE

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Provider Statement of Patient/Client Rights and Responsibilities

Patients/Clients have the **Right** to:

- …be treated with dignity and respect.
- …fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- …their treatment and other patient information kept private. Only by law may records be released without patient permission.
- …access care easily and in a timely fashion.
- …a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- …share in developing their plan of care.
- …the delivery of services in a culturally competent manner.
- …information about the organization, its providers, services, and role in the treatment process.
- …information about provider work history and training.
- …information about clinical guidelines used in providing and managing their care.
- …know about advocacy and community groups and prevention services.
- …freely file a complaint, grievance, or appeal, and to learn how to do so.
- …know about laws that relate to their rights and responsibilities.
- …know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.

Patients/Clients have the **Responsibility** to:

- …treat those giving them care with dignity and respect.
- …give providers the information they need, in order to provide the best possible care.
- …ask their providers questions about their care.
- …help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- …let their provider know when the treatment plan no longer works for them.
- …tell their provider about medication changes, including medications given to them by others.
- …keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- …let their provider know about their insurance coverage, and any changes to it.
- …let their provider know about problems with paying fees.
- …not take actions that could harm others.
- …report fraud and abuse.
- …openly report concerns about quality of care.
- …let their provider know about any changes to their contact information (name, address, phone, etc).
- …understand and help develop plans and goals to improve their health.

I have read and understood my **Rights** and **Responsibilities**.

Patient Signature_____Date_____