5825 Mountain Creek Road NE • Sandy Springs, GA • 30328 • 678.708.2709

MASSAGE INTAKE FORM

In order to provide the best care possible, please fill out all information as accurately and thoroughly as possible. It is better that you give the therapist what you consider too much information, rather than not enough information.

Name:_______________________________________ Social Security Number ______- ______- _______

Full Address:____ City_______________ State________ Zip ________

Home Phone: ( ) _______________ Work: ( )__________________ Cell ( ) _________________________

Email Address: ____

Date of Birth: Month___________________ Day_______ Year ____________ Age ___________

Hobbies:____

Emergency Contact and their relationship to you:____

( ) _______________________________________

Have you ever received massage or bodywork before? Y/N If yes, what kind of massage was it?___________________

Would you like the therapist to focus on or stay away from any specific area? Y / N

Focus on: ____

Stay away from: ____

HEALTH INFORMATION:

Do you have or are you any of the following (Please circle Y=Yes or N=No):

Smoker? Y / N
High/Low Blood Pressure? Y / N
Epilepsy? Y / N
Frequent Headaches? Y / N
Nausea? Y/ N

Pregnant? Y / N
Allergies? Y / N
Seizures? Y / N
Varicose Veins? Y / N
Dementia? Y / N

Contagious Disease? Y/ N
Heart Conditions? Y / N
Diabetic? Y / N
Cancer? Y / N

Are you currently suffering from any pain related to traumatic experience (car accident, sports injury, surgery)? Y / N

If yes, briefly explain (what and when):____

Are you currently taking any medications or supplements (prescription and non-prescription)? Y / N

If yes, name(s) of medication(s) and how often taken____

____

Do you have any conditions that may require a doctor’s note? Y / N

PLEASE BRIEFLY SUMMARIZE IN YOUR OWN WORDS THE REASON FOR YOUR VISIT (Please be as specific as possible):

____

____

____

How did you hear about us? (Please check as many as apply):

☐ Regular Business Card

☐ Referred by a friend (If so, who can we thank for your visit with us?) _________________________

☐ Facebook ☐ LinkedIn ☐ Twitter ☐ YouTube ☐ Groupon

☐ Massage Business Card (Where did you receive the card?) ______________________________

☐ Other (Please be specific) ____

Informed Consent

Dr. John N. Thomas and/or the authorized personnel of The Running Doctor have informed me that it is not uncommon that patients experience some increased discomfort after receiving an adjustment, physio-therapeutic or physical-therapeutic modalities. If this happens I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I can call the number listed below during office hours for emergency attention. If I am out of town, or unable to contact the doctor, I can present myself to an emergency room. If any laboratory or other diagnostic procedures or tests were performed outside of this office I understand that the doctor will notify me of the results at my next scheduled appointment.

By signing below I,_____________________________________, consent to the administration of chiropractic care, adjustments, and other chiropractic procedures, including, if required, diagnostic x-rays, physio-therapeutic or physical-therapeutic modalities on me or my child/children by Dr. John N. Thomas and/or authorized personnel. I have been given the opportunity to discuss with Dr. John N. Thomas and/or authorized personnel, the nature and purpose of chiropractic adjustments/care and its adjunctive therapies or modalities. I understand that chiropractor, Dr. John N. Thomas and/or the authorized personnel make no claim to cure the above conditions or any others described during consultation or within these confidential. I further understand and am informed that, as in all types of healthcare, in the practice of chiropractic there are some very slight risks to treatment, including but not limited to, muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my or my child/children best interests. I understand that results are not guaranteed.

I have read the above consent, I have had the 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 me or my child(ren) present condition and for any future conditions for which I (we) receive treatment.

Patient's Name: ____ Date Signed________________

Signature of Patient/Parent/Guardian: ____

Doctor's Signature:____

If any problems or emergencies arise call 678.705.2709

Authorization for Release of Medical Records

To Whom It May Concern:

____

____

____

____

Pursuant to Title 31, Chapter 33 of the Official Code of Georgia, I ______________________________________
(Patient's Full Name)
request that my health records and/or x-rays, of copies thereof be released to me personally or released/mailed to:

The Running Doctor
Dr. John N. Thomas, D.C.
5825 Mountain Creek Road, NE
Sandy Springs, GA 30328
(Health Care Provider)

I, ___________________________ understand that I am responsible for any costs incurred for copying and/or mailing these records.

Signature of Patient:____ Date: ____________________

Signature of Guardian (if other that Patient): __________________________________ Date:_____________