Patient Name: _____

Date: _____

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

PATIENT INTAKE FORM

In order for us to better serve you; we must have all available information regarding your present health. Please provide us with the following information.

PATIENT HISTORY *PLEASE PRINT (above line):*

_____

(Patients Name) **(Social Security #)** **(Date of Birth)** **(Age)**

_____

(Address) **(City, St. & Zip)** **(E-mail address)**

_____

(How Long At Current Address) **(Marital Status)** **(Number of Children)** **(Driver's Lic. No. /State)**

(___)_____ (___)_____ (___)_____

(Home Phone#) **(Work Phone#)** **(Cell Phone#)**

_____

(Employer) **(Occupation)** **(How Long Employed?)**

_____

(Address) **(Shift Worked)**

_____

(Name of Spouse) **(Employer)** **(Occupation)**

_____ (___)_____

(Address) **(Phone #)** **(How Long Employed)**

_____

(Social Security #) **(Driver's Lic. No. /State)**

_____ (___)_____

(Emergency Contact) **(Relationship to Patient)** **(Phone #)**

_____

(Current Full Address)

Notice: Payment is expected as services are rendered. Allied Healthcare Clinics, Inc. requires payment arrangements to be made on the first visit.

NAME OF PERSON RESPONSIBLE FOR PAYMENT: _____

Medical Insurance Coverage

_____

(Insurance Company) **(Insured's Name)** **(Policy #)**

Patient Name: _____

Date: _____

(Group #) (Identification #) (Policy Type: Group or Private) (HMO, POS, PPO)

Spouse's Group Insurance Information:

(Insurance Company) (Insured's Name) (Policy #)

(Group #) (Identification #) (Policy Type: Group or Private)

INSTRUCTIONS:

Please show us where your pain is by marking the diagram with the following symbols.

Use P! for Pain

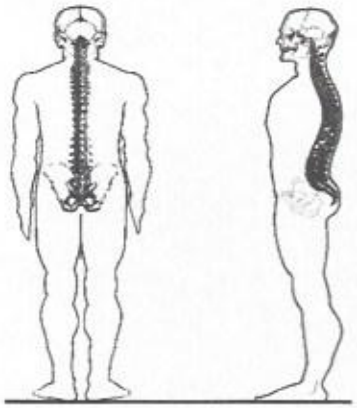
Use N! for Numbness

Use B! for Burning Sensations

Use A! for Aching Pain

Use S! for Stabbing Pain

Use H! for Headache Pain



Left Right

Please check all of the following symptoms and signs which you now have or have Had within the last 6 months. An understanding of your health status will facilitate care.

A. Musculo-skeletal

- ☐ Weakness
- ☐ Twitching
- ☐ Stiff neck
- ☐ Neck pain
- ☐ Muscle spasm in neck
- ☐ Grinding noise in neck
- ☐ Pain in shoulders and/or arms
- ☐ Tight shoulder muscles
- ☐ Pins & needles in arms/ hands
- ☐ Cold hands
- ☐ Backache
- ☐ Swollen joints
- ☐ Painful joints/Arthritis
- ☐ Pain in legs
- ☐ Pins and needles in legs
- ☐ Tremors
- ☐ Foot trouble
- ☐ Cold feet
- ☐ Painful tail bone
- ☐ Hernia

- ☐ Poor circulation
- ☐ Varicose veins
- ☐ Pain in calf
- ☐ Strokes

C. Genito-Urinary

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Prostate problems
- ☐ Bladder infection
- ☐ Bed wetting

D. Respiratory

- ☐ Chronic cough
- ☐ Spitting blood
- ☐ Spitting phlegm
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Lung problems
- ☐ Asthma

F. Gastro-Intestinal

- ☐ Poor appetite
- ☐ Poor digestion
- ☐ Excessive hunger
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon trouble
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Jaundice
- ☐ Gall bladder trouble
- ☐ Stomach trouble

G. Eye, Ear, Nose, Throat

- ☐ Poor vision
- ☐ Crossed eyes
- ☐ Frequent colds
- ☐ Tonsillitis
- ☐ Sinus trouble

H. Skin

- ☐ Skin eruptions
- ☐ Itching
- ☐ Bruising
- ☐ Dryness
- ☐ Boils
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis

I. General/Other

- ☐ Headache
- ☐ Fever/chills
- ☐ Fainting
- ☐ Convulsions/seizures
- ☐ Insomnia
- ☐ Fatigue

Patient Name: _____

Date: _____

☐Spinal curvature
☐Faulty posture

B. Cardio-Vascular
☐Rapid heart beat
☐Slow heart beat
☐High/Low blood pressure
☐Pain over heart
☐Previous heart trouble
☐Swelling of ankles

☐Pneumonia
☐Smoker- Years_____

E. Endocrine
☐Kidney infection
☐Hot or cold flashes
☐Hyperthyroidism
☐Hypothyroidism
☐Pituitary problems
☐Kidney stones

☐Pain in eyes
☐Deafness
☐Earache/Dizziness
☐Ringing in the ears
☐Ear discharge
☐Nasal obstruction
☐Nose bleeds
☐Sore throat
☐Hoarseness
☐Hay fever/Allergies

☐Nervousness/Depression
☐Diabetes
☐Cancer

J. FOR WOMEN ONLY
☐Painful periods
☐Excessive flow
☐Irregular cycles
☐Vaginal discharge
☐Pregnant at this time

Family History:

If any of the following are relevant to your family medical history please indicate as follows:

	Mother	Father	Grandmother Maternal/ Paternal		Grandfather Maternal/ Paternal		Other
Cancer	☐	☐	☐	☐	☐	☐	_____
Heart disease	☐	☐	☐	☐	☐	☐	_____
High blood pressure	☐	☐	☐	☐	☐	☐	_____
Low blood pressure	☐	☐	☐	☐	☐	☐	_____
Kidney disease	☐	☐	☐	☐	☐	☐	_____
Tuberculosis	☐	☐	☐	☐	☐	☐	_____
Lung disease	☐	☐	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	☐	☐	_____
Polio	☐	☐	☐	☐	☐	☐	_____
German Measles	☐	☐	☐	☐	☐	☐	_____
Muscular Dystrophy	☐	☐	☐	☐	☐	☐	_____
Arthritis	☐	☐	☐	☐	☐	☐	_____
Epilepsy	☐	☐	☐	☐	☐	☐	_____
Rheumatism	☐	☐	☐	☐	☐	☐	_____
Rheumatic Fever	☐	☐	☐	☐	☐	☐	_____
Asthma	☐	☐	☐	☐	☐	☐	_____
Anemia	☐	☐	☐	☐	☐	☐	_____
Sinus Trouble	☐	☐	☐	☐	☐	☐	_____
Backaches	☐	☐	☐	☐	☐	☐	_____

PLEASE BRIEFLY SUMMARIZE IN YOUR OWN WORDS THE REASON FOR YOUR VISIT:

_____

_____

_____

_____

Patient Name: _____

Date: _____

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:_____