



170 Bastille Way · Suite A · Fayetteville · GA · 30214 · 770.460.1911

AUTO ACCIDENT FORM

History of Occurrence

- Pedestrian Driver Passenger Middle Front Passenger Right Front
- Passenger Left Front Passenger Center Rear Passenger Right Rear

Patient Vehicle Type

- Compact Mid-size Full-size SUV Pick up Motorcycle

Second Vehicle Type

- Compact Mid-size Full-size SUV Pick up Motorcycle

Third Vehicle Type

- Compact Mid-size Full-size SUV Pick up Motorcycle

Road Conditions

- Dry Icy Wet Clear Foggy Dark

Road Type

- Concrete Asphalt Gravel Dirt

Were you aware the accident was going to occur? Yes No

Were you wearing your seat belt? Yes No

Did your airbag deploy? Yes No

Does your car have a head rest? Yes No Position: Up Down Middle

Head position: Straight Left Right ----- Level Down Up

Was your car braking? Yes No

Was your car moving? Yes No
(mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60
 61-70 >70

Was the other vehicle braking? Yes No

Was the other vehicle moving? Yes No
(mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60
 61-70 >70

Collision Details

First Impact: Hit by another vehicle Hit another vehicle Hit by an object Hit an object
(on the) Front Front-Right Front-Left Left Right Right-Rear Rear Top

Second Impact: Hit by another vehicle Hit another vehicle Hit by an object Hit an object
(on the) Front Front-Right Front-Left Left Right Right-Rear Rear Top

Collision Results

Body was thrown: Forward Backward Right Left Can't Remember

Head Hit: Windshield Rear-view mirror Steering wheel Dashboard
 Back front seat Side window/door Another persons body

Chest Hit: Steering wheel Dashboard Back front seat Side window/door
 Another persons body

Shoulders Hit: Shoulder harness Side window/door Back of front seat
 Another persons body

Knees Hit: Steering wheel Dashboard Back front seat Door Panel
 Center console Another persons body

Hips Hit: Steering wheel Dashboard Back front seat Door Panel
 Center console Another persons body

Vehicle Damage

First Vehicle: Totaled Significant Damage Light Damage No Damage
Second Vehicle: Totaled Significant Damage Light Damage No Damage
Third Vehicle: Totaled Significant Damage Light Damage No Damage

Were you hospitalized? Yes No

Current Symptoms: Pain Numbness Stiffness Weakness

CONTINUE WITH CHIEF COMPLAINT 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.*

PLEASE PRINT (above the line):

(Patient Name) (Social Security #) (Full Date of Birth) (Age)

(Address, City, Zip) (E-mail address)

(How Long At Current Address) (Marital Status) (Number of Children)

() () ()
(Home Phone#) (Work Phone#) (Cellular Phone#)

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

(Address) (Shift Worked)

(Name of Spouse) (Employer) (Occupation)

()
(Address) (Phone #)

(Social Security #) (How Long Employed)

()
(Name of Emergency contact) (Relationship) (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 Group Insurance Coverage (Provided Through Employer or Private)

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

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

Spouse's Group Insurance Information:

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

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

AUTO ACCIDENTS: Date of Accident: _____ Time of Accident _____

Please Indicate (X) Where You Were Struck

Please specify left, right, front, back or side on both vehicles.



OTHER CAR _____
(Year / Make / Model)

YOUR CAR _____
(Year / Make / Model)

In your own words, please describe what happened in the accident:

CHECK ALL THAT APPLY:

- Were you: () Driver () Passenger () Front Seat () Back Seat on () Right or () Left
Wearing seatbelt? () Yes () No () Lap belt only () Shoulder Belt Only () Both Belts
Stopped when struck? () How fast were you going? _____ MPH Other car? _____ MPH
Did accident catch you by surprise? () Yes () No Was your headrest () Up or () Down?
Wearing glasses or hat? _____ Still on? () Yes () No Loss of Consciousness? () Yes () No
Body movement during accident: () FWD then Back () Back then FWD () Side to Side
Hand position: () On Wheel () Other _____ Brakes on when struck? () Yes () No
Did anything on your body hit anything on the inside of the car? () Yes () No

Please describe how you felt:

During the accident: _____

Immediately After the accident: _____

Later That Day: _____

The Next Day: _____

After the accident I:

went home

went to work

went to Dr. _____'s office () MD () DO () Chiropractor () Other _____

was taken to the hospital by ambulance/other _____

At the hospital I received: () Treatment () X-Rays () CT () MRI () Exam () No Care

The following medications were prescribed: _____

The medications have: () been effective () not been effective made me () drowsy () sick

Did you have any physical complaints before the accident? () Yes () No If Yes, please describe:

Does your current condition prevent you from doing your regular job duties? () Yes () No

INSTRUCTIONS:

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

Use P! for Pain

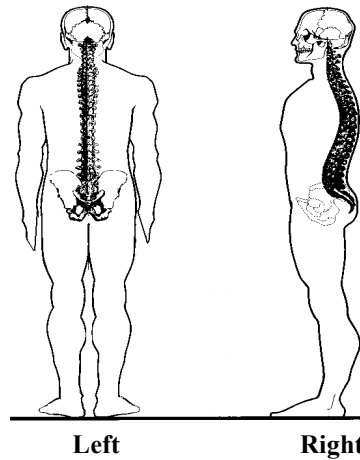
Use N! for Numbness

Use B! for Burning Sensations

Use A! for Aching Pain

Use S! for Stabbing Pain

Use H! for Headache Pain



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

- 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

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

- Frequent colds
- Tonsillitis
- Sinus trouble

H. Skin

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

I. General/Other

- Headache
- Fever/chills
- Fainting

- Cold feet
- Painful tail bone
- Hernia
- 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

- Difficulty breathing
- Lung problems
- Asthma
- Pneumonia
- Smoker- Years _____

E. Endocrine

- Kidney infection
- Hot or cold flashes
- Hyperthyroidism
- Hypothyroidism
- Pituitary problems
- Kidney stones

G. Eye, Ear, Nose, Throat

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

- Convulsions/seizures
- Insomnia
- Fatigue
- 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		Grandfather		Other
			Maternal/ Paternal	Paternal/ Maternal	Maternal/ Paternal	Paternal/ Maternal	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Backaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

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?) _____
- 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 Allied Healthcare Clinics, Inc., 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 the authorized personnel of Allied Healthcare Clinics, Inc. I have been given the opportunity to discuss with Dr. John N. Thomas and/or the authorized personnel of Allied Healthcare Clinics, Inc., the nature and purpose of chiropractic adjustments/care and its adjunctive therapies or modalities. I understand that chiropractic, Dr. John N. Thomas and/or the authorized personnel of Allied Healthcare Clinics, Inc., makes 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/children 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: 770-460-1911.

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, or copies thereof be released to me personally or released/ mailed to:

Allied Healthcare Clinics, Inc.
Dr. John N. Thomas, D.C.
170 Bastille Way, Suite A
Fayetteville, GA 30214
(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 than Patient): _____

Date: _____