



170 Bastille Way · Suite A · Fayetteville · GA · 30214
Phone: 770 460 1911

IDD THERAPY® PATIENT INTAKE FORM

PATIENT INFORMATION (Please Print)

Patient Name: _____ Today's Date: _____
(First and Last)

Date of Birth: _____ Age: _____
(Month, Day and Year)

Single _____ Married _____ Male _____ Female _____

Email Address: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone #: (____) _____ Cell Phone #: (____) _____

Work Phone #: (____) _____

Employed? Y N Employer Name: _____

Address: _____
(Include City and Zip Code)

Occupation: _____

Social Security #: _____ Drivers License #: _____

Emergency Contact: _____

Relationship to You: _____ Phone # (____) _____

INSURANCE INFORMATION

Insurance Carrier: _____ Phone #: (____) _____

Insured's Name: _____
(If different then patient)

Insured's Social Security #: _____ HMO POS PPO
(If different then patient)

Policy #: _____ Group #: _____

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PATIENT HISTORY INFORMATION (Please Print)

Please describe the condition you are currently dealing with:

When did the condition start? _____ Was it (circle one): Sudden or Gradual?

Who is your General Practitioner? _____ Phone #: (____) _____

Have you ever had any surgeries? Y or N

If yes, please list and date: _____ Date: _____
_____ Date: _____
_____ Date: _____

When were your last x-rays taken? _____

Have you had an MRI? Y or N

If yes, when and where? _____ (Date) _____ (Name and address)

Have you ever had Nerve Conduction Velocity (NCV/EMG) testing done? Y or N

Have you had any previous low back or neck pain? Y or N If yes, when? _____

Duration: _____

What helps relieve the pain? Nothing Rest Heat Medication: _____

What makes it worse/irritates it? (circle one) Bending Twisting Lifting Sitting Standing Walking

Is the pain (circle one): Sharp Dull Throbs Stiff Aching Numb Weak
Sore Burning Tingling Cramping Shooting

Is the pain radiating? Y or N Is it on the right or left side? R L Both

Where is the pain? _____

Is the pain: Constant On and Off In the morning only In the evening only

How would you describe the pain on a scale of 1 – 10 (1 being low to none, 10 being excruciating)? _____

Do you do any lifting while at work? Y or N

On average, how many pounds? _____

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: _____