



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

MESSAGE 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 Code _____

Home Phone: () _____ - _____ Work: () _____ - _____ Cell: () _____ - _____

Email/URL _____

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 Pregnant? Y / N Contagious Disease? Y / N

High/Low Blood Pressure? Y / N Allergies? Y / N Heart Conditions? Y / N

Epilepsy? Y / N Seizures? Y / N Diabetic? Y / N

Frequent Headaches? Y / N Varicose Veins? Y / N Cancer? Y / N

Nausea? Y / N Dimensia? Y / N

Are you currently suffering from any pain related to traumatic experience (i.e.: Car accidents, sports injuries, surgeries)? Y / N
If yes, briefly explain (what and when): _____

Are you currently taking any medications or supplements (prescription and non-prescript.) 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):



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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) _____

Is there anyone you know who could benefit from any of the services we have to offer? _____ If yes, please write their name and a number we could contact them at: _____

I attest that the above is true and accurate to the best of my knowledge

Signature _____

Date: _____

MESSAGE CONSENT FORM

- Focused attention and manual therapy will be given as agreed upon by the therapist and client for predetermined goals of stress reduction, relief of muscular discomfort and/or health promotion. My therapist has discussed the potential benefits and possible side effects of this therapy. I have been given an opportunity to ask questions.
- I, as the client, agree to provide complete and accurate health information, including pregnancy, and notice of health changes at successive appointments as appropriate.
- I understand that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment.
- Written refusal is requested from your primary care provider if:
 - 1) you are currently receiving care or
 - 2) you have specific medical condition or symptoms for which you take medication or receive periodic evaluation or treatment.
- I will immediately inform my therapist of any unusual sensation or discomfort, so that the application of pressure of strokes may be adjusted to my level of comfort.
- I understand that the massage is not sexually oriented in any way and that any illicit or suggestive remarks or behavior on my part will result in immediate termination of session. The unclothed body will be properly draped at all times for your warmth, sense of security and as a mark of massage professionalism.
- I understand that this professional massage is therapeutic in nature and is performed by a trained, state-licensed therapist.
- I understand that by signing this form, I give my consent to receive the treatment discussed in this and all future sessions and agree that my presence at subsequent sessions shall be construed to be validation of this written consent.

I have read this form thoroughly and hereby freely give my permission to be massaged.

Date: _____

Signature: _____



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Authorization for Release of Medical Records

To Whom It May Concern:

Pursuant to Title31, 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: _____