

Massage Intake

Name _____ D.O.B. _____ Date _____

Address _____ City _____

State _____ Zip _____ Phone _____

Please mark "X" for conditions that apply

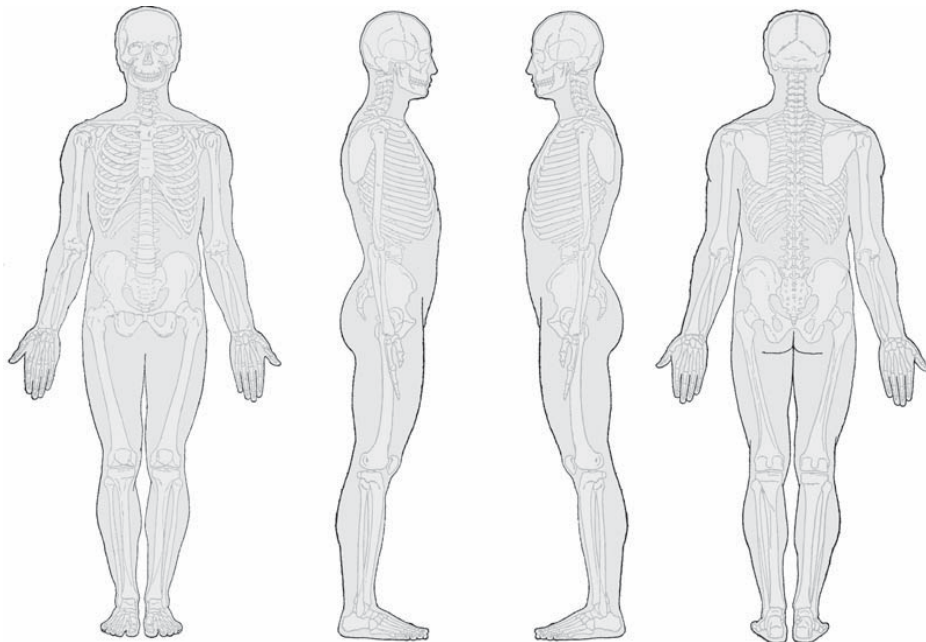
- | | | |
|---|--|---|
| <input type="checkbox"/> muscle/joint pain | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> sleep difficulties |
| <input type="checkbox"/> sprains, strains | <input type="checkbox"/> convulsions | <input type="checkbox"/> allergies |
| <input type="checkbox"/> arthritis/tendonitis | <input type="checkbox"/> blood clots | <input type="checkbox"/> circulatory problems |
| <input type="checkbox"/> numbness, tingling | <input type="checkbox"/> varicose veins | <input type="checkbox"/> swollen legs |
| <input type="checkbox"/> cancer | <input type="checkbox"/> blood pressure | <input type="checkbox"/> spider veins |
| <input type="checkbox"/> asthma | <input type="checkbox"/> infectious diseases | <input type="checkbox"/> respiratory problems |
| <input type="checkbox"/> digestive problem | <input type="checkbox"/> hemophilia | <input type="checkbox"/> athlete's foot |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> skin conditions | <input type="checkbox"/> anxiety, stress |
| <input type="checkbox"/> pregnancy | <input type="checkbox"/> diabetes | <input type="checkbox"/> depression |

Other: _____

Reason For Massage: (Please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Recovery | <input type="checkbox"/> Sports Performance | <input type="checkbox"/> Injury Management |
| <input type="checkbox"/> Relaxation / Stress Relief | <input type="checkbox"/> Other _____ | |

Please mark your area(s) of discomfort, tension and/or pain on the figure:



NEXT LEVEL

SPINE & SPORTS INJURY CENTER

I _____ understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease. Because massage must not be performed under certain circumstances, I have made the therapist aware of my existing medical conditions. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge. If I experience any pain or discomfort during the session, I will immediately communicate it to the therapist so the treatment can be adjusted. If I have any questions about the therapy, I know that I am free to ask, and that the therapist will happily answer.

I have read the above copy of the therapist's policies, I understand them and agree to abide by them.

Signature _____

Date _____



PHYSICAL THERAPY | CHIROPRACTIC | MASSAGE THERAPY

CANCELLATION/TARDINESS POLICY

Effective as of April 1, 2020, Next Level Spine and Sports Injury Center will be instituting the following Cancellation and Tardiness Policy.

WE REQUEST 24 HOURS NOTICE FOR THE RESCHEDULING OR CANCELLING OF AN APPOINTMENT. APPOINTMENTS RESCHEDULED OR CANCELLED WITHOUT 24 HOURS NOTICE WILL BE CHARGED A \$35 CANCELLATION FEE. IF YOU ARE 8 MINUTES LATE OR MORE, YOUR APPOINTMENT WILL NEED TO BE RESCHEDULE AND YOU WILL BE CHARGED A CANCELLATION FEE.

All cancellation fee must be paid prior to scheduling your next appointment.

While we hope this will not be necessary, patients who repeatedly violate our Cancellation and Tardiness Policy may not be allowed to reschedule with Next Level.

Thank you for being a valued patient, and for your understanding as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Patient Signature _____ Date _____

Date of session _____ Time of session _____ Length of Session _____

S _____

O _____

A _____

P _____

Date of session _____ Time of session _____ Length of Session _____

S _____

O _____

A _____

P _____

Date of session _____ Time of session _____ Length of Session _____

S _____

O _____

A _____

P _____

Date of session _____ Time of session _____ Length of Session _____

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Date of session _____ Time of session _____ Length of Session _____

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Date of session _____ Time of session _____ Length of Session _____

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