NEXT LEVEL
SPINE & SPORTS INJURY CENTER

# Massage Intake

Name _____ D.O.B. _____ Date_____

Address _____ City_____

State _____ Zip _____ Phone _____

Please mark "X" for conditions that apply

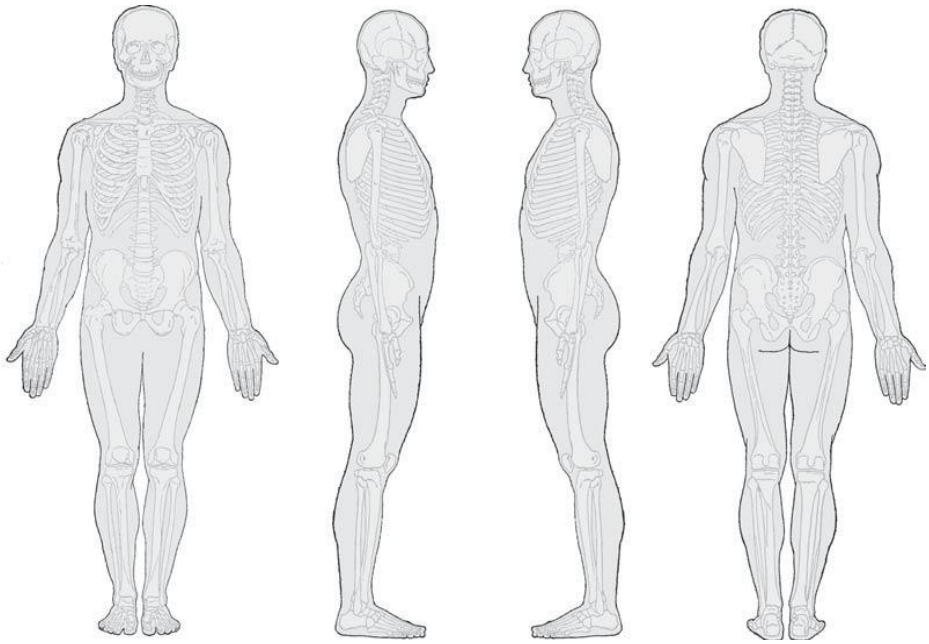
| | | |
|---|---|---|
| ___ muscle/joint pain | ___ osteoporosis | ___ sleep difficulties |
| ___ sprains, strains | ___ convulsions | ___ allergies |
| ___ arthritis/tendonitis | ___ blood clots | ___ circulatory problems |
| ___ numbness, tingling | ___ varicose veins | ___ swollen legs |
| ___ cancer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

Other: _____

Reason For Massage: (Please check all that apply)

| | | |
|---|---|---|
| ___Recovery | ___Sports Performance | ___Injury Management |
| ___Relaxation / Stress Relief | ___Other _____ | |

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



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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_____

NEXT LEVEL

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_____