Massage Therapy Intake Form

Name: _____ Email: _____

Address: _____ City: _____State:_____ Zip: _____

Phone: _____Occupation: _____

Birthday: _____ How did you hear about us: _____

What are your massage goals for today's session?

□ Relaxation/Stress Relief □ Therapeutic □ Increase Circulation □ Pain Relief □ Stretching

Have you had professional massage/bodywork done before? □ Yes □ No How Recently? _____

What type of pressure do you prefer? □ Light □ Medium/Firm □ Deep

Please check one of the following symptoms you are currently experiencing:

□ Back Pain □ Leg Pain □ Tingling/Numbness in Leg

□ Neck Pain □Arm Pain □ Tingling/Numbness in Arm

When did your symptoms begin? _____

Do you wake up at night because of your pain? □ Yes □ No

What makes your pain better? □ Lying Down □ Sitting □ Walking □ Bending □ Other: _____

What makes your pain worse? □ Lying Down □ Sitting □ Walking □ Bending □ Other: _____

Past Spine Treatment History

Have you ever had back or neck pain before? □ Yes □ No If so when? _____

Have you had back or neck surgery? □ Yes □ No If so, when? _____

Have you had any of the following treatments for your pain?

Injections? □ Yes □ No Did it help? _____

Physical Therapy? □ Yes □ No Did it help? _____

What did it consist of? _____

Rate your pain on a scale of 0-10. With 0 being no pain, and 10 being worst pain. _____

Have you had any accidents or surgeries in the past 2 years? □ Yes □ No _____

Are you currently taking any medications? □ Yes □ No _____

Do you have any allergies? □ Yes □ No _____

Re you currently suffering from an illness, cold, flu, or any other contraindication?

□ Yes □ No _____

Are you pregnant or nursing? □ Yes □ No

Please carefully read the following information and sign where indicated.

Your Responsibility

If you have certain medical conditions or symptoms, massage may be problematic for you. Be certain to inform the therapist of any conditions or symptoms you presently have. A referral from your primary health care provider may be required prior to treatment being provided.

If at any point during the massage I am uncomfortable or uneasy with the procedures being administered and/or if I experience pain, I understand it is my responsibility to IMMEDIATELY inform the massage therapist, so that the procedures can be adjusted to a level of comfort or terminated.

I further understand that the massage therapy is not a substitute for diagnosis and treatment by a medical osteopathic doctor. What we discuss is not a replacement for their advice.

I agree to provide complete and accurate information about my health history today, and to tell my therapist about any changes in the future. If I do not, it may affect my therapy, or result in the termination or our relationship.

For patients under the age of 18, we recommend the parent/guardian meet the therapist at the time the waiver is signed. It is not required for the parent/guardian to stay in the room or on the premises, but have the choice to do so.

I declare that I am presently in proper physical to utilize massage services and I do it with full knowledge and understanding of the possible risk which I may sustain personally. I understand that massage is not a replacement for medical care. I affirm that I have informed the therapist of all known medical conditions and symptoms. If I experience any pain of discomfort, I will inform the therapist so that the pressure and/or environment can be adjusted appropriately. I understand this document, have had the opportunity to ask questions about the information, and my questions have been answered. I am over the age of 18 years of age and have legal capacity to understand and agree to this document. I release Nevada Advanced Pain Specialists and all of its employees and contractors from any liability which may arise from or out of my failure to abide by the terms of this document.

Any illicit or suggestive comments or actions made by me will result in immediate termination of the session and I will be full responsible for the payment.

Cancellation Policy

Please understand that when you forget or cancel your appointment without giving enough notice we miss the opportunity to fill that appointment time, and the clients on our waiting list miss the opportunity to receive services. Appointments are confirmed 24 hours in advance as a courtesy because we know how easy it is to forget an appointment that was made months or weeks in advance. Since these services are reserved for you personally, any appointment that is cancelled within 24 hours of the service will be subject to a fee 50% of their service. “No call, no show” appointments will be charges 100% of their service.

Patients Name (print): _____

Signature: _____ Date: _____