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 before? ☐ yes ☐ no How recently? _____

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

Please check the following symptoms you have:

☐ 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 they help? _____

Physical Therapy: ☐ yes ☐ no Did it help? _____

What did it consist of? _____

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

Have you had any accidents/surgeries in the past 2 years? ☐ yes ☐ no _____

Are you currently taking any medications? ☐ yes ☐ no _____

Do you have any allergies? ☐ yes ☐ no _____

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

☐ yes ☐ no _____

Are you pregnant or nursing? ☐ yes ☐ no

NEVADA ADVANCED PAIN SPECIALISTS
CENTER FOR INJURY REHABILITATION

Denis G. Patterson, DO
Board Certified Pain Medicine
Board Certified Physical Medicine & Rehabilitation

Ali Nairizi, MD, MS
Fellowship Trained Pain Specialist
Anesthesiologist

5578 Longley Lane
Reno, NV 89511

5931 S. Los Altos Parkway
Suite 101
Sparks, Nevada 89436

tele 775.284.8650
fax 775.284.8654
www.nvadvancedpain.com

Please carefully read the following information and sign where indicated.

Your Responsibility:

If you have certain medical conditions or symptoms, massage therapy 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 massage therapy is not a substitute for diagnosis and treatment by a medical or 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 of 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 premises, but they have the choice to do so.

I declare that I am presently in proper physical condition 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 or 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 it, and my questions have been answered. I am over 18 years of age and have the 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 form or out of my failure to abide by the terms of this document.

Any illicit or suggestive comments or actions made by be will result in immediate termination of the session and I will be fully 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 at least 24 hours in advance as a courtesy because we know how easy it is to forget an appointment that was made months in advance. Since these services are reserved for you personally, any appointment that is not cancelled within 24 hours of the service will be subject to a fee 50% of their service. “No call, no show” appointments will be changed 100% of their service.

Patients Name (print): _____

Signature: _____ Date:_____