ADVANCED SPINAL CARE

CHIROPRACTIC & REHAB OF LAKELAND

Massage Therapy Patient Intake

Today's Date:_____/_____/_____

Name:_____ Age_____ Date Of Birth_____

Local Address_____ City_____State____ Zip_____

Out of Town Address_____ City_____State____ Zip_____

Marital Status_____ Sex_____ S.S.#_____ Home Phone_____Cell. Phone_____

Email Address:_____

Employer_____ Occupation _____ Address _____

Phone_____ Spouse _____ Employer_____

Emergency Contact_____Phone_____Relationship_____

How did you hear about our office? *Check an option below:*

☐ Yellow Pages ☐ Drive By ☐ Walk-In ☐ Internet ☐ Referral (Please tell us who) _____ ☐ Other: _____

Current complaint

Please list the reason you are here to see a Massage Therapist_____

_____

How long have you had these symptoms_____are they ☐Improving ☐Worsening ☐About the same

How did the condition start_____ Is it ☐Mild ☐Moderate ☐Severe

What makes it worse _____ What makes it better_____

Current Health

Are you currently under any doctor's care for an illness or injury? If so, please list his/her name and

address_____ Nature of illness or injury_____

If you are currently taking any prescription or nonprescription medications, list them below

_____

Please list any medications you are allergic to_____

Please indicate your height and weight _____What is your usual blood pressure_____/_____

Health History

List any operations, surgeries or medical procedures

Date_____ Procedure_____ Date_____ Procedure_____

Date_____ Procedure_____ Date_____ Procedure_____

If you have ever had in the past or currently have any serious illnesses or injuries, please list

Date_____ Condition_____ Date_____ Condition_____

Date_____ Condition_____ Date_____ Condition_____

Please list any significant family illnesses_____

Do you have a pacemaker? ☐Yes ☐No If yes, please alert our chiropractic assistant

Please list any other electrical device that you currently wear_____

Do you smoke ☐Yes ☐No ___pack/day/wk Do you drink alcohol ☐Yes ☐No ____oz/day/wk

Have you ever had massage therapy ☐Yes ☐No If yes, last date of treatment_____

What are your overall expectations from your treatment with our massage therapist (s)

_____

It is my choice to receive massage therapy and I give my consent to receive treatment. I understand that a massage therapist cannot diagnose illness, disease or any other medical, mental or emotional disorder nor do they prescribe medical treatment, pharmaceuticals or perform spinal manipulations.

- WOMEN ONLY I hereby declare that to the best of my knowledge, ☐I am ☐I am not pregnant.
- CONSENT TO TREAT A MINOR: I hereby authorize and give consent for the Massage Therapist at Advanced Spinal Care to treat my minor child through massage therapy _____ (Please Print Minor's Name)

Patient Signature_____ (Parent/Guardian signature if under 18 years of age)

GENERAL/FINANCIAL POLICY

Welcome to Advanced Spinal Care of Lakeland. We strive to provide you with excellent Chiropractic care in a clean, friendly, professional setting and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current. All self pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover, American Express or Care Credit.
- If you do not have your payment (s), your appointment may be rescheduled.
- If you are unable to keep a scheduled appointment, please notify us no later than the day before so that we may offer that time to another patient. There is a $25.00 charge for missing a half hour massage appointment and a $50.00 charge for missing a full hour massage appointment without proper notification. Hour massage appointments will be booked with a credit card on file.
- A returned check will result in a $25.00 service charge and all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $5.00.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. WE ARE HERE TO HELP YOU.

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

_____ _____ _____

Printed Name Signature of Patient/Legal Guardian Date