Blue Q Health & Wellness

Name:_____ Today's Date:_____

Address:_____ City/State/Zip:_____

Insurance:_____ Date of birth: _____

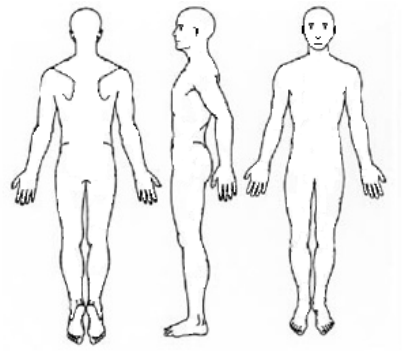
Phone:_____ Email:_____

Main Complaint/Reason for Visit: _____

_____

_____

Area(s) of complaint (circle on diagram); Please describe in the blank space to the right of the diagram:



Stiffness Soreness Numbness Tingling Weakness Swelling Dull Achy Sharp Stabbing Burning

If you are experiencing pain, please circle a number: (No Pain) 0-1-2-3-4-5-6-7-8-9-10 (Severe)

When did your symptom(s) begin?_____

How often do symptoms occur? (Circle One) Occasional Intermittent Frequent Constant

Is the complaint getting: (Circle One) Better Worse Same/Not Changing N/A

Affected Activities of Daily Living: _____

_____

_____

What makes the problem(s) better?_____

What makes the problem(s) worse?_____

Medical History:

Have you treated elsewhere for this condition? N or Y (Date of last visit: _____)

Name/Location/ Phone: _____

Do you have a Family Physician: N or Y (Do we have your permission to contact them: Y or N)

Name/Location: _____

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727-530-7778

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Have you been hospitalized last 5 yrs? N or Y **(explain)** _____

Have you had Surgery last 5 yrs? N or Y **(explain)** _____

Have you had a serious Accident/Injury last 5 yrs? N or Y **(explain)** _____

Do you have any Allergies? N or Y **(list)** _____

Are you currently taking any Medication? N or Y **(list)**_____

WOMEN ONLY:
Are you currently pregnant? Y or N (Yes, due date: _____)
Date of Last Physical Exam: _____ Where? _____

***REVIEW OF SYMPTOMS*: Which of the following conditions do you now have or have you previously had?** (circle)

Arthritis	Asthma	Sinus Issues	Blood Clotts	Allergies
Tuberculosis	Diabetes	Vertigo	ADD/ADHD	Epilepsy
Migraine/HA's	Thyroid	High BP	Low BP	Heart Trouble
Pacemaker	HIV/AIDS	Cancer	Polio	Scoliosis
Mental/Emotional		Prostate Trouble	Hormonal	Dislocation
Disc Herniation/Bulge		Rheumatic Fever	Bone Fracture	Osteoporosis
Kidney Disease		Digestive Trouble	Acid Reflux	Sleep Disorder

Family History:

	Cancer	Diabetes	Blood Pressure	Heart Attack	Stroke	Osteoporosis	Arthritis	Scoliosis	Other
Father									
Mother									
Sibling (s)									
Child/Children									
Grandparent(s)									

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I understand that my health information will remain private and will not be shared with anyone without my written or verbal approval. I have received a copy of Blue Q Health and Wellness PLLC Notice of Privacy Practices. I understand that Blue Q Health and Wellness PLLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Blue Q Health and Wellness PLLC at any time to obtain a current copy of the Notice of Privacy Practices. I authorize the sharing of my health information with the following party or parties listed below:

_____

(List any names of lawyers, doctors, or family members who may contact us for your health information)

_____ _____
Patient Name (or Guardian) Date

_____ _____
Representative of Blue Q Health and Wellness Date

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SOFT TISSUE THERAPY INFORMATION:

Name: _____ Today's Date: _____

Have you had a professional massage before? Y or N

What type of massage are you seeking? Relaxation Deep Tissue _____

What pressure do you prefer? Light Medium Heavy

Are you sensitive to any fragrances or have a skin allergy to oils? Y or N

Are there any areas that you do not want treated? Y or N

Please circle any of the following that are true for you:

Cancer (current)	Blood Clots or Deep Vein Thrombosis (current or past)	
Stroke	Burns or Open wounds (current)	
Rheumatoid Arthritis	Chemo or Radiation treatment (current)	
Recent Surgery	Broken Bones or Fracture (current)	
Pregnant (current)	Automobile Accident (current)	**None apply to me**

Are you taking any medication? Y or N

What are your goals for this treatment session?

_____

_____

I hereby request and consent to the performance of massage therapy or neurosomatic therapy on me (or on the client named below for whom I am legally responsible) by the licensed massage therapist named below and any of the soft tissue therapist located at Blue Q Health and Wellness. I have had an opportunity to discuss with the licensed practitioner below and/or with other office or clinic personnel the nature and purpose of the therapy and other procedures. I understand that results are not guaranteed. I understand and am informed that in the practice of soft tissue therapy there are some risks to treatment, including but not limited to bruising and emboli. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely upon the practitioner to exercise judgment during the course of the procedure which they feel at the time, based upon the facts then known to him or her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Client Signature_____ Date _____

LMT Signature _____ Date_____

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Blue Q Health and Wellness Policies

Cancellations and Missed Appointment Policy

Appointments canceled same day or missed (no call/no show) will incur either a **$30 charge, the full service amount, or count toward the service package**. All appointments must be canceled or rescheduled by the close of the day prior (7:00pm the day before) in order to avoid the charge or package deduction.

I acknowledge and understand the policy and have been given a copy for my records (if requested).

_____ _____

Signature Date